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STUDY ON DEPRESSION, ANXIETY AND ADJUSTMENT AMONG INSTITUTIONALISED OLD PEOPLE

J.JERUS ALBERT BRITTO,
DR. B. SELVARAJ



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**STUDY ON DEPRESSION, ANXIETY AND ADJUSTMENT AMONG
INSTITUTIONALISED OLD PEOPLE**

J.JERUS ALBERT BRITTO,

Guest Lecturer of Psychology

Government Arts College, Coimbatore-18, India

DR. B. SELVARAJ

Associate Professor of Psychology

Government Arts College, Coimbatore-18, India

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Author Helpline: +91 76988 26988

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Vishal Parmar, (Forensic Psychologist)

Forensic Psychology, Institute of Behavioural Science, Gujarat Forensic Sciences University, Gandhinagar, Gujarat. INDIA

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Message from the Desk of Editor

It gives me immense pleasure to welcome all to explore/publish/ comment in/on our journal, The International Journal of Indian Psychology (IJIP). There are a lot of challenges which the growing psychological face in the realms of basic necessities in life. Psychological thoughts can play a very distinct role in bringing about this change. One of the key objectives of research should be its usability and application. This journal attempts to document and spark a debate on the research focused on psychological research and ideas in context of emerging geographies. The sectors could range from psychological education and improvement, mental health, environmental issues and solution, health care and medicine and psychological related areas. The key focus would however be the emerging sectors and research which discusses application and usability in social or health context.

We intended to publish case reports, review articles, with main focus on original research articles. Over objective is to reach all the psychological practitioners, who have knowledge and interest but have no time to record the interesting cases, research activities and new innovative procedures which helps us in updating our knowledge and improving our treatment.

Finally, I would like to thank RED'SHINE International Publications, for this keepsake, and my editorial team, technical team, designing team, promoting team, indexing team, authors and well wishers, who are promoting this journal. With these words, I conclude and promise that the standards policies will be maintained. We hope that the research featured here sets up many new milestones. I look forward to make this endeavour very meaningful.

Prof. Suresh Makvana, PhD¹

Editor in Chief,
HOD & Professor, Dept. of Psychology,
Sardar Patel University,
Vallabh Vidyanagar,
Gujarat, India

¹ ksmnortol@gmail.com

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INTRODUCTION

“Last scene of all,
that ends this strange, eventful history.
is second childishness and more oblivion,
sans teeth, sans taste, sans everything”.

- William Shakespeare in “As you like it”

Most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person. At the moment, there is no United Nations standard numerical criterion, but the UN agreed cutoff is 60+ years to refer to the older population. Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. The common use of a calendar age to mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous (WHO, 2013).

The world's elderly population, which was 70 million in 2001, is estimated to cross 112 million by the year 2016. In India alone the number of people over 60 years is expected to touch 60 million in the next census report (Rouchell, 2001).

The age of 60 or 65, roughly equivalent to retirement ages in most developed countries is said to be the beginning of old age. In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people; in some cases, it is the loss of roles accompanying physical decline which is significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible (Gorman, 2000).

Population ageing is a worldwide phenomenon. In India, the trend has resulted in various challenges on account of gradual erosion of the traditional joint family system and the inability of government to support any section of the elderly population besides retired government employees. Today, even as senior citizens are more active and independent owing to health consciousness, medical interventions and easy accessibility to medical facilities, most of them are dependent on the younger generation for physical care and financial security and are forced to adjust in a society that stereotypes ageing as deteriorated physical and mental health (Siva Raju, 2000).

DEMOGRAPHIC PROFILE OF INDIA'S ELDERLY

	Total	Male	Female
60+ Population (in million)	76.6	37.8	38.8
Percentage of 60+ population	7.4	7.1	7.8
Decadal growth rate of 60+	35.2	28.6	42.2
Old age dependency ratio (Number of 60+ per 100 persons in the 15-59 age group)	13.1	12.4	13.8

	Total	Male	Female
Literacy rate of 60+	36.3	52.8	20.3
Marital Status of 60+ (%) Never Married	2.0	2.5	1.5
Married	64.5	82.1	47.3
Widowed	33.1	15.0	50.7
Divorced / Separated	0.4	0.3	0.5

Source: Computed from 2001 Census data2

OLD AGE HOMES

The very concept of an old age home is new to India. An old age home is usually the place, a home for those old people who have no one to look after them or those who have been thrown out of their homes by their children. The place is of course like home where the inmates get all the facilities for a routine living, like food, clothing and shelter.

In traditional Indian household, the joint family system which upheld the authority of the head of the family offered care and security to their elderly members. But with rapid industrialization, technical advancement and urbanization, the younger people started migrating to the cities for better prospects. As a result, the joint family system is gradually moving towards nuclear families and elderly are left alone to tend for themselves (Owen, 2000).

All these necessities are well looked after but, the much-needed love and care of loved ones is of course sadly missing; for, how can outsiders provide solace? In these homes, it is very interesting and even touching to talk to people whether they are men or women. At least in India till now, the old people staying away from the home, from their children, or left to themselves is not considered to be in a very happy situation. If, in any home we talk to the inmates, their story would be much the same- turmoil in the family, disgust against the old and finally, the removal of the elders from the family scene. It is the family atmosphere, and being among their flesh and blood that, most of the old people miss at the old age home.

They do get their daily needs fulfilled but, from where will the love of the dear ones come? The stories of almost all the old people are the same and very dismal. It is the breakup of the system of the joint family and the introduction of a nuclear family that has brought this unhappy situation enter our society and the old age homes have had to come up to cater to the needs of the elderly.

No matter how well they are looked after in these homes, a single visit to an old age home brings depression to the onlooker as, no one - Yes, no one seems to be happy there. It is very clear to all who visit an old age home that, all the inmates are there, not for the love of being away from home and independent but, because there is no better alternative left for them, once they are neglected and unwanted in their homes by their own children. The only solace is that, they are getting their daily requirements of shelter and food - if not the bonds of love from the family (Personal correspondence, January 2001. Marybeth Weinberger, UN).

DEPRESSION IN OLD AGE

The World Health Organization has identified major depression as the fourth leading cause of death worldwide (Rouchell, 2001).

Depression is a serious illness in the community and is a serious medical problem. The word depression is used to describe a mood, symptom or syndrome. It can be characterized by intensity as mild, moderate and severe. As a symptom, depression is manifested as disturbances in cognitive, affective (or) psychomotor areas. These symptoms are frequently found concomitant to chronic illness (or) as side effects of medications (Ugarriza, 2002).

Depression is the most common psychiatric illness of late life. The most common emotional disorder in the elderly population is depression, which is often overlooked by health care professionals and family members (Jones, 2003). Depression among elderly adults has become a major public health problem associated with mortality and suicidal behavior because it is either undiagnosed or misdiagnosed. Depression in elderly adults can be debilitating and can subsequently affect functional, cognitive and emotional health. This increases risks for infections, falls, injury and poor nutrition (Hamid Elhawary, 2003).

CAUSES OF DEPRESSION

The changes that often come in later life—retirement, the death of loved ones, increased isolation, medical problems—can lead to depression. Causes and risk factors that contribute to depression in older adults include:

- Health problems – Illness and disability; chronic or severe pain; cognitive decline; damage to body image due to surgery or disease.
- Loneliness and isolation – Living alone; a dwindling social circle due to deaths or relocation; decreased mobility due to illness or loss of driving privileges.
- Reduced sense of purpose – Feelings of purposelessness or loss of identity due to retirement or physical limitations on activities.
- Fears – Fear of death or dying; anxiety over financial problems or health issues.
- Recent bereavement – The death of friends, family members, and pets; the loss of a spouse or partner.
- Alcohol makes symptoms of depression, irritability, and anxiety worse and impairs one's brain function. Alcohol also interacts in negative ways with numerous medications, including antidepressants.

SYMPTOMS OF DEPRESSION

Recognizing depression in the elderly starts with knowing the signs and symptoms. Depression red flags include:

- Sadness
- Fatigue
- Abandoning or losing interest in hobbies or other pleasurable pastimes
- Social withdrawal and isolation (reluctance to be with friends, engage in activities, or leave home)

- Weight loss or loss of appetite
- Sleep disturbances (difficulty falling asleep or staying asleep, oversleeping, or daytime sleepiness)
- Loss of self-worth (worries about being a burden, feelings of worthlessness, self-loathing)
- Fixation on death; suicidal thoughts or attempts

Other symptoms that suggest depression include:

- Intense, pervasive sense of guilt
- Thoughts of suicide or a preoccupation with dying
- Feelings of hopelessness or worthlessness
- Slow speech and body movements
- Inability to function at work, home, and/or school
- Seeing or hearing things that aren't there

Some clues of Depression in the elderly are as follows:

- Unexplained or aggravated aches and pains
- Feelings of hopelessness or helplessness
- Anxiety and worries
- Memory problems
- Lack of motivation and energy
- Irritability
- Loss of interest in socializing and hobbies
- Neglecting personal care (skipping meals, forgetting meds, neglecting personal hygiene) (Melinda Smith, Lawrence Robinson and Jeanne Segal, 2012).

EFFECTS OF DEPRESSION

Depression prevents a person from enjoying life like he/she used to. But its effects go far beyond mood. It also impacts one's energy, sleep, appetite and physical health (Melinda Smith, Lawrence Robinson and Jeanne Segal, 2012). Depression doubles an elderly person's risk of cardiac diseases and increases their risk of death from illness. At the same time, depression reduces an elderly person's ability to rehabilitate. Depression also has been associated with increased risk of death following a heart attack. For that reason, making sure that an elderly person you are concerned about is evaluated and treated is important, even if the depression is mild.

Depression also increases the risk of suicide, especially in elderly white men. The suicide rate in people aged 80 to 84 is more than twice that of the general population. The National Institute of Mental Health considers depression in people aged 65 and older to be a major public health problem. In addition, advancing age is often accompanied by loss of social support systems due to the death of a spouse or siblings, retirement, or relocation of residence. Because of changes in an elderly person's circumstances and the fact that elderly people are expected to slow down, doctors and family may miss the signs of depression. As a

result, effective treatment often gets delayed, forcing many elderly people unnecessarily struggle with depression (Joseph Goldberg, 2012).

ANXIETY IN ELDERLY

Anxiety may affect twice as many older adults as depression, according to new research. Researchers say generalized anxiety disorder (GAD) may be the most common mental disorder among the elderly, although little is known about how to treat the disorder among older adults. Studies have shown that generalized anxiety disorder is more common in the elderly, affecting 7% of seniors, than depression, which affects about 3% of seniors (Jennifer Warner, 2006).

As many as one quarter of all people experience anxiety to an unhealthy extent, and older people can be at particular risk. Seniors may experience more troublesome anxiety than other age groups for several reasons: they experience more losses, suffer from more pain and chronic conditions, are often on multiple medications that might exacerbate anxiety. Some experts suggest that in general anxiety is equally prevalent in all adult age groups but perhaps is less often reported by seniors, and not as accurately diagnosed and treated as in younger people (Jeannette Franks, 2013).

Feeling anxious or nervous is a common emotion for people of all ages and a normal reaction to stress. Feeling anxious can help us handle problems and strange situations, and even avoid danger. It is normal to feel anxious about illnesses, new social interactions, and frightening events. But when one feels anxious often and the anxiety is overwhelming and affects daily tasks, social life, and relationships, it may be an illness.

Anxiety is a common illness among older adults, affecting as many as 10-20 percent of the older population, though it is often undiagnosed. Phobia—when an individual is fearful of certain things, places or events—is the most typical type of anxiety. Among adults, anxiety is the most common mental health problem for women and the second most common for men, after substance abuse.

Older adults with anxiety disorders often go untreated for a number of reasons. Older adults often do not recognize or acknowledge their symptoms. When they do, they may be reluctant to discuss their feelings with their physicians. Some older adults may not seek treatment because they have suffered symptoms of anxiety for most of their lives and believe the feelings are normal. Complicated or chronic grief is often accompanied by persistent anxiety and grieving spouses may avoid reminders of the deceased (Geriatric Mental Health Foundation, 2009).

Major Types of Anxiety Disorders in Older People

- Acute stress disorder: Anxiety and behavioral disturbances that develop within the first month after exposure to an extreme trauma.

- Post-traumatic stress disorder (PTSD): Symptoms of acute stress disorder that persist for more than one month.
- Panic attacks: A sudden, unpredictable, intense, illogical fear and dread.
- Social anxiety: A preoccupation with how a person is viewed by others.
- Generalized anxiety disorder (GAD): A pattern of excessive worrying over simple, everyday occurrences and events.
- Phobias: Irrational fear of situations such as heights, or fear of objects, such as snakes.
- Obsessive-compulsive disorder (OCD): A pattern of intrusive thoughts that assault the mind and produce extreme anxiety that can only be mitigated by an action, such as hand washing in a ritualistic way (Jeannette Franks, 2013).

CAUSES OF ANXIETY IN OLD PEOPLE

A number of things can contribute to an anxiety disorder:

- Extreme stress or trauma
- Bereavement and complicated or chronic grief
- Alcohol, caffeine, drugs (prescription, over-the-counter, and illegal)
- A family history of anxiety disorders
- Other medical or mental illnesses or
- Neurodegenerative disorders (like Alzheimer's or other dementias).

The stresses and changes that sometimes go along with aging—poor health, memory problems, and losses—can cause an anxiety disorder. Common fears about aging can lead to anxiety. Many older adults are afraid of falling, being unable to afford living expenses and medication, being victimized, being dependent on others, being left alone, and death.

Older adults and their families should be aware that health changes can also bring on anxiety. Anxiety disorders commonly occur along with other physical or mental illnesses, including alcohol or substance abuse, which may hide the symptoms or make them worse. It is also important to note that many older adults living with anxiety suffered an anxiety disorder (possibly undiagnosed and untreated) when they were younger. A stressful event, such as the death of a loved one, can cause a mild, brief anxiety, but anxiety that lasts at least six months can get worse if not treated.

SYMPTOMS OF ANXIETY IN THE ELDERLY

- Excessive worry or fear
- Refusing to do routine activities or being overly preoccupied with routine
- Avoiding social situations
- Overly concerned about safety
- Racing heart, shallow breathing, trembling, nausea, sweating
- Poor sleep
- Muscle tension, feeling weak and shaky
- Hoarding/collecting

- Depression
- Self-medication with alcohol or other central nervous system depressants (Geriatric Mental Health Foundation, 2009).

ADJUSTMENT IN THE ELDERLY

'Adjustment' and 'life satisfaction' are important components of successful ageing. 'Adjustment' is defined as 'the restructuring of the individual's attitude and behaviour in response to the new situation by integrating his/her expression with the expectations and demands of society'. It includes semblance between mental state and external circumstances, a degree of continuity between past and present patterns of adjustment, acceptance of old age and death, euphoria, adequate financial security, and extent of participation in community and recreational activities. Major determinants of successful ageing include well-adjusted attitudes, sense of wellbeing and usefulness, zest for life, active participation in society, and aiming for contentment in later years (Mishra, 1987).

Perceptions of change are more important to age-related adjustment than the actual change. Self-esteem and self-rated adjustment to ageing largely depend on the individual's personality and interaction with physical and social environment. In turn, this interaction creates attitudes that help to meet the challenges of ageing. In India, factors that influence the extent of adjustment mainly include the degree of flexibility, living arrangements, economic status, marital satisfaction, attitude towards retirement, self-perception after ageing, physical and mental health including any disability, attitude towards the future and death, and involvement in family and society. Factors that determine life satisfaction are mental disposition and enthusiasm, acceptance of one's actions, parity between desired and achieved goals, self-esteem, and optimism.

Old age is generally a closing period in one's life span. Old age bring about a wide variety of problems. During the old age physical and psychological function declines. There is a decline in intellectual activity, social activity and physical health. The needs and problems of the elderly vary significantly according to their age, socio-economic status, health, living status and other such background characteristics (Nidhi Kotwal and Bharti Prabhakar, 2009).

Major determinants of successful ageing include age, marital satisfaction, family support and involvement, educational and professional success, economic well-being, health, satisfactory community participation and awareness of social support systems. In traditional Indian society, health and financial concerns of the elderly were the family's responsibility. However, sustaining such support in a modern society has become increasingly difficult owing to changes in family structure and consequent mobility of the younger generation - both within urban areas, and from rural to urban areas. There is also lack of control over family resources, and growth in individualism. Without much support from either the family or society, the elderly have no one to depend on, leading to greater alienation and isolation (Siva Raju, 2002).

Though the focus on ageing in India is still in its infancy, concerted and systematic efforts are being made to first understand and then intervene in various age-related issues. This is particularly evident in the living conditions of both community and institutionalized elderly (those living in old age homes), and beneficiaries of various senior-friendly programmes. However, an effort to study only the problem makes the approach one-dimensional. As age-related issues are multi-dimensional in nature, adopting a multidimensional approach of study is necessary (Amita Amin-Shinde. www.harmonyindia.org).

CAUSES OF ADJUSTMENT PROBLEMS

'Adjustment' is influenced by factors like rigidity and flexibility, role availability and involvement, types of family structure, living arrangements, marital satisfaction, interaction with family and society, financial status, approach towards retirement, self-perception, physical and mental health, disabilities, belief in karma, and attitude regarding the future and death. Factors influencing 'adjustment' in older females include deteriorating health and relationships with family and society and self-emotions. Females with lower frustration level are less resigned and aggressive. They are socially better adjusted, but need greater affiliation and nurturing compared to males (Ramamurti, 1976).

Once people cross the age of 50, they generally display poor adjustment and greater dissatisfaction with life. However, after retirement, they gradually adjust, and their life satisfaction index increases. Negative effects of ageing become more pronounced after the age of 70. Factors that contribute to adjustment problems of retired persons mainly include financial constraints, physical weakness, mental tension, widowhood and loneliness, feeling neglected by family, friends and society, and fear of death. Living arrangements with children and adjustment of the elderly are found to be closely associated. In situations where children live separately, the quality of relationship and frequency of meetings with the elderly has a positive association with their adjustment (Gupta Niharika, 2001).

Stein and Ross (2005) implied that the elderly individuals in a nursing home viewed their lives with extreme pessimism and that "institutionalization is not in the best interest of the elderly". They indicated that the elderly seem to feel abandoned and useless, due to their lack of input into the surrounding environment. Also, Stein and Ross (2005) implied that the relatives of the institutionalized individuals "never have their parents committed without some remorseful feelings". Hamilton (1985) also implied that the elderly deem their situation as a misfortune due to the inability of the individual to live at home. The elderly individual not living in his own home may be inhibited from reaping any benefits he could acquire from his former familiar surroundings. Therefore, Hamilton (1985) suggested that the elderly are faced with a crucial decision; either adapt to the institutional setting or disengage oneself. Numerous studies have been accumulated, and many seem to indicate that institutionalized elderly, when compared to their non-institutionalized counterparts, demonstrated an impaired adaptation and adjustment.

NEED FOR THE STUDY

Ageing is a universal process. In the words of Seneca, “old age is an incurable disease”, however, as Sir James sterling commented “you do not heal old age, you protect it, you promote it and you extend it.” In 1966, the Mental Health Advisory Committee to Govt. of India suggested a prevalence rate of mental illnesses of 20 per 1000 population with 14 per 1000 in rural areas. It has been a too long time, where most people regard the two conditions – depression and aging to be natural partners. After all, many of the changes that come with age are depressing.

It has been documented that elderly are more prone to psychological problems and depression is the commonest geriatric psychiatric disorders. Old age is not a disease in itself, but the elderly are vulnerable to long term diseases of insidious onset such as cardiovascular illness, cancer, diabetes, musculoskeletal and mental illnesses. In fact, the elderly in India face a multitude of psychological, social and physical health problems. As age advances, there is increased morbidity and functional loss. The presence of a variety of depressive factors and occurrence of varying life events greatly impact one’s psychological status, making them more prone to depression.

Depression is among the commonest psychiatric disorder among elderly, which is manifested as major or minor depression characterized by a collection of depressive symptoms. The level of depression among the elderly is increasing in especially those living in the sheltered accommodation or users of home care services. This can be found in the reports and statistics from studies where it showed many of the depressed elderly have suicidal thoughts in their mind. Such emotional effect should be handled in a better way and with immediate preventive measures.

The goal of this study is to explore the magnitude and risk factors of the problem of depression in elderly people residing in the old age homes.

REVIEW OF LITERATURE

A literature review is a text written by someone to consider the critical points of current knowledge including substantive findings as well as theoretical and methodological contributions to a particular topic. Literature reviews are secondary sources, and as such, do not report any new or original experimental work. Also, a literature review can be interpreted as a review of an abstract accomplishment. Most often associated with academic-oriented literature, such as a thesis, a literature review usually precedes a research proposal and results section. Its main goals are to situate the current study within the body of literature and to provide context for the particular reader (en.wikipedia.org/wiki/Literature_review, 2013).

The review of literature of the present study involved the following:

- Depression in old people
- Causes of Depression in old people
- Symptoms of depression in old people
- Anxiety in old people

- Adjustment problems in old people
- Causes of adjustment problems in old people

DEPRESSION IN OLD PEOPLE

Archana Singh and Nishi Misra (2009) conducted a study on loneliness, depression and sociability in old age. The sample comprised of 55 elderly persons (35 men and 20 women) in the age group of 60-80 years. The subjects for the sample were selected from the older adults of a Delhi-based region residing in the housing societies. The revised UCLA (University of California, Los Angeles) loneliness scale (Russell *et al.*, 1980), Beck depression inventory (Beck *et al.*, 1961) and Sociability subscale of Eysenck personality profiler (Eysenck & Eysenck, 1975) were the tools used. Results reveal that there are no significant gender differences in elderly men and women with respect to loneliness and depression. Elderly men, however, were found to be more sociable as compared to elderly women. A significant positive correlation is found between depression and loneliness, which is significant at the 0.01 level, i.e., there is an increase in the level of depression with an increase in loneliness among elderly men and women. A negative, though insignificant, relationship was found between sociability and loneliness. No significant relationship was found between sociability and depression. In the male elderly persons, a significant positive correlation was found between depression and loneliness. Sociability and loneliness were negatively correlated, though not significantly. Female elderly persons manifested a significant positive correlation between depression and loneliness.

Ankur Barua, Mihir Kumar Ghosh, Nilamadhab Kar and Mary Anne Basilio (2011) conducted a community-based mental health study and found that the point prevalence of depressive disorders in the elderly population of the world varies between 10% and 20%, depending on cultural situations. The search engines that were utilized for electronic data from the internet were MEDLINE, PUBMED, GOOGLE, YAHOO, EMBASE, PsycINFO, and the Cochrane Collaboration Database for original human research articles in the English literature published from January, 1, 1955 through December 31, 2005. All the studies that constituted the sample were conducted between 1955 and 2005. Included are only community-based, cross-sectional surveys and some prospective studies that had not excluded depression at baseline. These studies were conducted on a homogenous community of the elderly population in the world, who were selected by a simple random sampling technique. After applying the inclusion and exclusion criteria on published and indexed articles, 74 original research studies that surveyed a total of 487 275 elderly individuals, in the age group of 60 years and above, residing in various parts of the world, were included for the final analysis. The median prevalence rate and its corresponding interquartile range were calculated. The chi-square test and chi-square for linear trend were applied. A *P* value of <.05 was considered as statistically significant. The median prevalence rate of depressive disorders in the world for the elderly population was determined to be 10.3% (interquartile range [IQR], 4.7%-16.0%). The median prevalence rate of depression among the elderly Indian population was determined to be 21.9% (IQR, 11.6%–31.1%). Although there was a

significant decrease in the trend of world prevalence of geriatric depression, it was significantly higher among Indians, in recent years, than the rest of the world.

Ankur Barua and Nilamadhab Kar (2010) determined the prevalence of depression among the elderly population of rural areas of Udupi district, Karnataka, India and determined the validity and reliability of WHO (five) Well-being Index (1998 version) as a screening instrument to identify depressive disorders in elderly population in this Indian setting. This cross-sectional study was conducted over a period of eight months (from March 1 to October 31, 2002) in the three taluks of Udupi, Kundapura, and Karkala; belonging to the Udupi district of South India on 627 people in the age group of 60 years. Simple random sampling was used. The WHO (five) well-being index (1998 version) was validated against the major International Classification of Diseases and Related Health Problems 10th Revision (ICD-10) depression inventory of mastering depression in primary care version 2.2. Proportions and their 95% confidence intervals were calculated and Kappa statistics was applied to determine the reliability of the screening instrument. $P \text{ value} < 0.05$ was considered statistically significant. The prevalence of depression in elderly population was determined to be 21.7% (95% CI = 18.4 - 24.9). The Indian version of WHO-five well-being index (1998 version) showed a sensitivity of 97.0%, specificity of 86.4%, positive predictive value of 66.3% and an overall accuracy of 0.89. The Kappa statistics showed significantly high reliability of $k = 0.71$. The Indian version of "WHO (five) Well-being Index (1998 version)" was found to be an effective instrument for identifying depression in elderly Indian community.

A survey was conducted by Bagulho (2001) in Scandinavia on depression in older people. The purpose of this study was to estimate prevalence rate of depression among the older people. The study included 146 elderly living in the community. The data was collected based on diagnostic and Statistical Manual of Mental Disorders. The result revealed that prevalence rate of depression increases with age, and the prevalence rate was 6.4% in women and 14.3% in men. The study recommended that poor health status and cultural barriers were important factors for depression.

An evaluator approach with one group pre-test post-test design was adopted by Nalini (2006). Simple random sampling was used for the selection of four old age homes in Mangalore. 430 inmates, above the age of 65 years from were assessed for estimating prevalence rate of depression by Geriatric Depression Scale. Pre-test was administered using Hamilton Rating Scale for depression on 50 inmates of Abhaya Ashraya. The participants attended daily session of 45 minutes of the Horticulture therapy for 25 days. On 26th day Post-test was administered by Hamilton Rating Scale for depression to the participants after horticulture therapy. The collected data were analysed by using descriptive and inferential statistics. The prevalence rate of depression was high (65.65%) among institutionalized elderly. Similarly, the mean- Post-test depression score was lower than the mean Pre-test depression scores ($t(49) = 1.873$ $p > 0.05$). Post-test scores for mild and moderate depression were significantly lower than pretest scores for mild and moderate level of depression. Post-test scores for severe depression were not significantly lower than pre-test scores for severe depression.

Mian-Yoon Chong, Hin-Yeung Tsang, Cheng-Shen Chen, and Tze-Chun Tang. (2001) studied the prevalence of depressive disorders among community-dwelling elderly and assessed the socio-demographic correlates and life events in relation to depression in a randomised sample of 1500 subjects aged 65 and over. Research psychiatrists conducted all assessments using the Geriatric Mental State Schedule. The diagnosis of depression was made with the GMS-AGECAT (Automated Geriatric Examination for Computerised Assisted Taxonomy); data on life events were collected with the Taiwanese version of the Life Events and Difficulties Schedule. One-month prevalence of psychiatric disorders was 37.7%, with 15.3% depressive neurosis and 5.9% major depression. A high risk of depressive disorders was found among widows with a low educational level living in the urban community, and among those with physical illnesses. Contrary to most previous reports, we found that the prevalence of depressive disorders among the elderly in the community in Taiwan is high and comparable to rates reported in some studies of UK samples.

Jariwala Vishal, Bansal, Patel Swati and Tamakuwala Bimal (2010) did a cross-sectional study to explore the magnitude and risk factors of problem of depression in elderly people residing in the old age homes and among those living at home in both, affluent and slums of Surat city. A total of 105 elderly people aged 60 years were interviewed. It was found that the elderly had moderately high (39.04%) depression. It was also found that those aged who are severely depressed and who require an institutional treatment are more in old age homes (25.71%), followed by those living in the affluent areas (22.8%) and those living in the slums (11.4%). The prevalence of depression according to marital status was found to be significantly higher in the elderly who were single (never married), widowed, divorced or separated. Severe depression old age is more in affluent area and old age home and it is twice that of slum area, though a statistically significant depression in particular group was not observable. It was observed that illiterates have a much lower rate of depression (26.6%) than literates (44%). This association was not observable in the slum area; however those residing in the affluent areas and in the old age homes had a higher rate of severe depression among the literates. In this study, 14.3%, 6.7% and 10.5% individuals were chewing tobacco, smoking and consuming alcohol respectively and only 2 (1.9%) were habituated to all of these three.

CAUSES OF DEPRESSION IN OLD PEOPLE

A correlational study was done by Louhlin (2004) to assess the depression and social support of elderly adults. A sample of 25 home bound elderly were screened for depression using long form of the Geriatric Depression Scale (GDS). Twenty (80%) participants were white, and five (20%) were African American. Nineteen participants were women and 6 were men. Participants ranged from age 75 to 98. Depression was significantly related to race ($\chi^2 p=.003$) with 55% of white participants and 40% of African American participants reporting depressive symptoms. Depression was significantly related to gender ($p=.009$) with 67% of men and 47% of women reporting mild depression. Using Pearson's correlation, depression was significantly negatively associated with increasing age, but positively associated with being a man, being unmarried, and needing formal social support.

In a meta-analysis of 25 studies, Kraaj, Arensman and Spinhoven (2000) studied the relationship of both specific types of negative life events and the total number of experienced events to depression in old age. Almost all negative life events appeared to have a modest but significant relationship with depression. The total number of negative life events and the total number of daily hassles appeared to have the strongest relationship with depression (respectively, combined $r = .15$, $n = 5,037$, and combined $r = .41$, $n = 461$), whereas sudden unexpected events were the only cluster of negative life events that seemed not to be related to depression scores (combined $r = .05$, $n = 857$). These findings suggest that providers and developers of intervention and prevention programs for elderly people should pay attention to the occurrence of negative life events. Special attention should be given to elderly people who have experienced an accumulation of stressful events and daily hassles, because they seem to be a group at greater risk.

Holwerda, Schoevers, Dekker, Deeg, Jonker and Beekman (2009) studied the association between depression and an increased risk of death in elderly persons. Generalized anxiety disorder, mixed anxiety-depression and depression were assessed in 4051 older persons with a ten-year follow-up of community death registers. The mortality risk of generalized anxiety, depression and mixed anxiety-depression was calculated after adjustment for demographic variables, physical illness, functional disabilities and social vulnerability. The results showed that in elderly persons, depression increases the risk of death in men. Neither generalized anxiety nor mixed anxiety-depression is associated with excess mortality. Generalized anxiety disorder may even predict less mortality in depressive elderly people. The relation between generalized anxiety disorder and its possibly protective effect on mortality has to be further explored.

Rajkumar, Thangadurai, Senthilkumar, Gayathri, Prince and Jacob (2009) assessed the socio-demographic profile, psychiatric morbidity, cognitive functioning, anthropometrics and disability status of 1000 participants aged over 65 years from Kaniyambadi block, Vellore, India using the following structured assessment tools.: Geriatric Mental State, Community Screening Instrument for Dementia, Modified CERAD 10 word list learning task, History and Aetiology Schedule Dementia Diagnosis and Subtype, WHO Disability Assessment Scale II, and Neuropsychiatric Inventory. Prevalence of geriatric depression (ICD-10) within the previous one month was 12.7%. Low income, experiencing hunger, history of cardiac illnesses, transient ischemic attack, past head injury and diabetes increased the risk for geriatric depression after adjusting for other determinants using conditional logistic regression. Having more confidants was the significant protective factor. Age, female gender, cognitive impairment and disability status were not significantly associated with geriatric depression. DSM-IV diagnosis of major depression was significantly correlated with experiencing hunger, diabetes, transient ischemic attack, past head injury, more disability and less nourishment; having more friends was protective. Geriatric depression is prevalent in rural south India. Poverty and physical ill health are risk factors for depression among elderly while good social support is protective.

Martha Bruce et al. (2002) reported the distribution, correlates and treatment status of DSM-IV major depression in a random sample of elderly patients receiving home health care for medical or surgical problems. The 539 patients ranged in age from 65 to 102 years; 351 (65%) were women, and 81 (15%) were nonwhite. The Structured Clinical Interview for DSM-IV Axis I Disorders was used to interview patients and informants. The patients had substantial medical burden and disability. According to DSM-IV criteria, 73 (13.5%) of the 539 patients were diagnosed with major depression. Most of these patients (N=52, 71%) were experiencing their first episode of depression and the episode had lasted for more than 2 months in most patients (N=57, 78%). Major depression was significantly associated with medical morbidity, instrumental activities of daily living, disability, reported pain and a past history of depression, but not with cognitive function or socio-demographic factors. Only 16 (22%) of the depressed patients were receiving antidepressant treatment and none was receiving psychotherapy. Five (31%) of the 16 patients receiving antidepressants were prescribed sub-therapeutic doses and two (18%) of the 11 who were prescribed appropriate doses reported not complying with their antidepressant treatment.

Wijeratne, Wijerathne, Wijesekara and Wijesingha (2000) assessed the prevalence of different degrees of depression, age and gender specific prevalence of depression and factors which are associated with depression among 100 senior citizens aged 60 years and above residing in elderly homes in the district of Colombo. A pre-tested, interviewer administered questionnaire in Sinhalese medium containing the Geriatric Depression Scale was used in the study. The prevalence of depression in the study population (n=100) was 56%, of which 23.2% had severe depression. Sixty percent of the female population (n=50) and 52% of the male population (n=50) were found to have depression. Prevalence of depression was found to be significantly higher among those with chronic diseases ($p<0.01$), family conflicts ($p<0.05$) and lack of psychological support ($p<0.05$). There was no significant association ($p>0.05$) with age, lack of financial support, literacy level, marital status and absence of a leisure time activity.

SYMPTOMS OF DEPRESSION IN OLD PEOPLE

Poongothai, Pradeepa, Ganesan and Mohan (2009) determined the prevalence of depression in an urban south Indian population. Subjects were recruited from the Chennai Urban Rural Epidemiology Study (CURES), involving 26,001 subjects randomly recruited from 46 of the 155 corporation wards of Chennai (formerly Madras) city in South India. 25,455 subjects participated in this study (response rate 97.9%). Depression was assessed using a self-reported and previously validated instrument, the Patient Health Questionnaire (PHQ) – 12. The overall prevalence of depression was 15.1% (age-adjusted, 15.9%) and was higher in females (females 16.3% vs. males 13.9%, $p<0.0001$). The odds ratio (OR) for depression in female subjects was 1.20 [Confidence Intervals (CI): 1.12–1.28, $p<0.001$] compared to male subjects. Depressed mood was the most common symptom (30.8%), followed by tiredness (30.0%) while more severe symptoms such as suicidal thoughts (12.4%) and speech and motor retardation (12.4%) were less common. There was an increasing trend in the prevalence of depression with age among both female ($p<0.001$) and male subjects ($p<0.001$). The prevalence of depression was higher in the low income group (19.3%)

compared to the higher income group (5.9%, $p < 0.001$). Prevalence of depression was also higher among divorced (26.5%) and widowed (20%) compared to currently married subjects (15.4%, $p < 0.001$).

Mohamed Sharif Mustaffa (2007) identified the level of depression among elderly, effect of depression on their emotion and the type of emotional support needed by the elderly in the institution. This study used mixed method: quantitative and qualitative approach. 26 elderly have been selected based on random sampling. They consist of 19 male and 7 female. The quantitative research instruments used were Zung Self-Rating Depression Scale (SDS) Inventory. Based on descriptive study, analysis using SDS index found all the 26 elderly tested were diagnosed with depression consisting of 19 elderly having a low level of depression, followed by 3 elderly having mild, 2 elderly moderate and 2 elderly severe. Furthermore, qualitative result analyzed, showed that emotional effects of elderly in the institution were critical. Symptoms such as regret, sad, sleep complaints, unable to sleep, feeling useless, and isolation of self, proved its criticality. In addition, for the type of emotional support, it was found that social support from the staff and from the institution itself is overwhelming, including from their children and other elderly in the institution.

Jansson (2004) conducted a study in Sweden, on gender differences, inheritability of depressive symptoms in the elderly. A sample of 959 twin pairs was assessed by the center for Epidemiological studies using Depression Scale. The results revealed that depressive symptoms were more (29%) in women than men. The study recommended that there would have been generated further evidence, concerning the genetic influences on depressive symptoms in the elderly.

Chun-Min Chen, Judy Mullan, Yung-Yu Su, David Griffiths, Irene A. Kreis and Herng-Chia Chiu (2012) investigated the change trajectories of both depressive symptoms and disability, as well as their associations over time. Participants included 442 community-dwelling older adults living in Taiwan, aged 65 years or older, who completed six waves of survey interviews. Depression was scored with the Short Psychiatric Evaluation Schedule and disability with the instrumental and physical activities of daily living measure. The results highlights that previous depressive symptoms significantly contributed to the advancement of more severe depressive symptoms. This also indicates that disability significantly contributed to the onset of depressive symptoms and vice versa. These findings demonstrate that disability is a stronger predictor of depressive symptoms and the prior existence of a health condition will lead to further deterioration of health conditions and that they often coexist.

Max Stek et al. (2005) studied the relationship between the presence of depressive symptoms and all-cause mortality in old age, especially the potential distorting effect of perceived loneliness. Within a prospective population-based study of 85-year-olds, the 15-item Geriatric Depression Scale and the Loneliness Scale were applied in all 476 participants. Depression was present in 23% and associated with marital state, institutionalization and perceived loneliness. When depression and perceived loneliness were not assessed during follow-up, depression nor did perceived loneliness have a significant effect on mortality.

However, those who suffered from both depression and feelings of loneliness had a 2.1 times higher mortality risk. The data suggest that the increased mortality risk attributable to depression in the presence of perceived loneliness may result from motivational depletion. There are strong indications that depression substantially increases the risk of death in adults, mostly by unnatural causes and cardiovascular disease.

ANXIETY IN OLD PEOPLE

A longitudinal study was conducted by Hein Van Hout, Aartjan Beekman, Edwin De Beurs, Hannie Comijs, Harm Van Marwijk and Marten De Haan (2004) from a large, community-based random sample ($n=3107$) of older men and women (55–85 years) in The Netherlands, with a follow-up period of 7.5 years. In men, the adjusted mortality risk was 1.78 (95% CI 1.01–3.13) in cases with diagnosed anxiety disorders at baseline. In women, no significant association was found with mortality. An association between anxiety disorders and subsequent mortality was found for men only. Older men with diagnosed anxiety disorders had 87% higher risk of mortality over 7 years of follow-up. The associations between anxiety and mortality in men remained after adjustment for co-morbid depression, the explanatory variables (activity, smoking, drinking, body mass index) and confounders (age, psychiatric treatment, functional limitations and chronic diseases, including heart disease and stroke). In women with anxiety disorders no association was found with subsequent mortality.

Patricia Parmelee, Ira. Katz and Powell Lawton (1993) assessed anxiety and depression among nursing home and congregate housing residents at yearly intervals. At baseline, modified DSM-III-R criteria yielded a 3.5% prevalence rate for anxiety or panic disorders. Another 13.2% reported milder symptoms not meeting diagnostic criteria. Anxiety was strongly associated with depression and with physical health, functional disability, and cognitive status. Follow-up data yielded an overall incidence rate of 2.3% for possible anxiety disorders; the majority of these cases were among those with mild anxiety at baseline. Change in anxiety was strongly associated with depression and, less consistently, with functional disability and cognitive status. Results are interpreted as indicating the indistinguishability of anxiety from depression in this frail elderly population.

Madnawat Singh, Kachhawa Singh (2007) examined the effect of age, gender, and living circumstances on elderly person's death anxiety. For this purpose, 299 persons attending public parks (average age = 70 years) were interviewed using the Death Anxiety Survey Schedule, which is a set of 10 questions related to death anxiety from an Indian perspective. Women, those relatively older, and those living with family were significantly more anxious about the word "death". The gender and age results in this Indian sample are similar to that in some western samples. The results reveal that those living with family have significantly higher death anxiety and may reflect cultural differences in anxiety about death.

Keller John et al (1982) focused on death anxiety in general for assessing the fear of death. A 12-item questionnaire was used to produce three factors; evaluation of death in general, belief in the hereafter, and death anxiety related to self. The study sample consisted of 901 subjects from young adults to older adult. Data showed that middle age and late-middle age

persons were significantly less anxious in regard to “evaluation of death in general” than their older and younger counterparts. Old age groups showed the least anxiety toward death anxiety related to self. Future research should differentiate between the concept of death and the process of dying.

Bharat Mimrot (2011) compared the death anxiety and studied the gender differences among the old people living in the family and in the institution at Aurangabad city. Both family sector units as well as institution sector unit were included in the study. The sample of the present study consists of 200 old persons. Death Anxiety Scale developed by Upinder Dhar, Savita Mehta and Santosh Dhar was used. The data were analyzed with the help of descriptive statistics i.e. Means, SDs, and multiple univariate 2 x 2 ANOVA for Death Anxiety. On the basis of these analyses, it was found there is a difference between old age people living in family and old age institutionalized people in terms of their death anxiety. On the basis of the mean value we interpret that old age people living in the family have high death anxiety (6.00) than institutionalized old people (5.44). There are significant differences between mean scores of old people living in the family and institutionalized old people on death anxiety ($F = 11.875$, $df_1 = 1$, $df_2 = 196$ $P < .001$), old people living in the family scoring higher than the institutionalized old people. No significant gender differences are observed in death anxiety.

Srivastava and Swetha (2002) assessed the effect of living arrangements and gender differences on emotional states and self esteem of old aged people. Structured questionnaire and self esteem inventory were administered to 120 old people aged 65 years and above (60 living with their children and 60 living in institutions). Results revealed that in the different emotional states the mean scores of anxiety, depression, guilt (13.66, 14.1, 17.39) of old age people living in institutions were higher than the mean scores of old age living with children on anxiety, depression and guilt (8.57, 11.5, 14.54) respectively. The results indicated that emotional states like anxiety, depression and guilt were more in old people living in institutions.

ADJUSTMENT PROBLEMS IN OLD PEOPLE

Nidhi Kotwal and Bharti Prabhakar (2009) attempted to study the physical needs and adjustments made by the elderly. The sample comprised of 100 elderly people (50 men, and 50 women) of Jammu city in the age group of 65 years and above. Purposive Sampling Technique was employed for sample selection. Results of the study revealed that majority of elderly men and women lived in joint families. Majority of the respondents were satisfied regarding their financial position. They had enough money to look after their needs. Majority of both elderly men and women liked to watch T.V in leisure time. Men liked to read newspapers and women preferred reading religious books. Majority of the respondents were facing the health problems like joint pains, failing vision, high blood pressure and diabetes. The findings revealed that the elderly were looked after by their spouses when they fell ill. It was observed that though most of the elderly were living in joint families still the spouses looked after each other when they fell ill.

Kothary and Sinha (2002) assessed the perception of old age, life style and problems faced by the elderly people in the rural areas of Rajasthan. Elderly persons, 60 years and above (16 females and 11 males) living in the village were selected for the study. Unstructured open ended interview schedule was used with an anthropological approach to ascertain in-depth perception of the respondents. The main problems felt individually by them as well as perceived for the elderly in general were related to health, money and loneliness. Only 2 out of 27 felt happy and satisfied with their life; both were widows with some independent source of income. The rest felt ignored and helpless.

Minal and Kamala (1995) conducted a study to find out the adjustment pattern of 30 institutionalized and non institutionalized elderly in New Delhi. The mean adjustment score of institutionalized elderly were 52.29 showing less adjustment and that of non institutionalized elderly was 34.43 showing high adjustment. This reveals that institutionalized elderly are having poor adjustment compared to non institutionalized elderly.

A study was done by Priya (1998) to assess psycho social determinants of 60 institutionalized and 60 non institutionalized elderly in New Delhi. This study revealed that feeling of loneliness is more for institutionalized older people whereas social support had a higher mean score for non institutionalized older people. This shows that social support is more amongst non institutionalized older people.

A comparative study of the non-institutionalized and institutionalized elderly on some psychological dimensions like pattern of adjustment, level of security, self perceived satisfaction and amount of coping was done by Pant (2003) in New Delhi. The sample consisted of 30 men, 15 of whom were living with their families and other 15 lived in an old age home. The tool used for data collection was Bell Adjustment Inventory. It was found that the desirable factors for adjustment are healthy family relationship, status of prominence in family, constructive leisure time activities and support network.

Gill and Saini (2002) investigated the emotional maturity patterns of institutionalized and non institutionalized elderly in Punjab. There were 140 subjects in this study. The results revealed that institutionalized males and females were found to be extremely unstable as compared to their non institutionalized counter parts. Higher percentage of extremely unstable behavior was also seen in institutionalized and non institutionalized elderly inmates irrespective of their sex.

Philip O. Sijuwade (2007) conducted a study on the Self-actualization and locus of control as a function of institutionalization and non-institutionalization in the elderly. The total number of male and female subjects was 48 with an age range between 65 and 90. The Personality Orientation Invention (POI) scale (Shostrom, 1996) and Levenson's (1983) modified internal-external locus of control measure were used. The data indicated that both institutionalized and non-institutionalized persons are less internal (or more highly external) in their world view than are the comparison groups. According to Levenson (1983), externally oriented individuals are less self-actualized than internally oriented individuals.

These results clearly suggested a lower degree of self-actualization among the elderly persons. When comparing the experimental and control groups, major differences are noted between these two. The lower mean scores reported for the institutionalized elderly are suggestive of the debilitating effect of old age homes.

Shikha Shakya, Meenakshi Singh and Pratibha Arya (2006) assessed the various difficulties or problems of old age. Fifty years old age people from different areas of Jhansi were selected. Results revealed that regarding social adjustment, significantly ($P < 0.05$) higher number of respondents (66%) want to make new friends to share their feelings after retirement and about 78% old people often take part in community activities. Mostly (96%) older people were respected by their children and 92% children of older people take their parents advice to solve the problems. Regarding physical adjustment, the old people feel physical changes in them and about 41 per cent old people feel physically helpless and dependent on others. Regarding vocational adjustment, 64% of old people do not want job after retirement and significantly ($P < 0.05$) higher number of old people (96%) were getting pension, provident fund and gratuity. In case of economic adjustment, 66% of older people feel economic security while in home, all the older people want to utilize their time with their grand children. Regarding emotional adjustment, significantly ($P < 0.05$) higher number of respondents (92%) were satisfied with their life and 84% share their old memories with their children

CAUSES OF ADJUSTMENT PROBLEMS IN OLD PEOPLE

RABELO, Dóris Firmino and NERI, Anita Liberalesso (2006) gathered data from Brazilian and foreign studies published between 1996 and 2005 which related subjective well-being, sense of psychological adjustment and stroke. The objective was identifying mediator variables of this relation among old people. Prospective and cross-sectional studies indicated that those affected by stroke showed less subjective well-being than the general population. Good cognitive capacity, effective social support, continuity of a productive occupation, keeping the competence in instrumental activities of daily living and good mood are factors which can affect positively the subjective and psychological well-being. Variables which can affect negatively the subjective and psychological well-being are functional incapacity, cognitive deficits, depression, difficulty in re-establishing the identity and restrictions to the possibility of executing activities and roles which contribute to the self-definition. The knowledge of the psychological implications of suffering stroke can benefit patients, families and professionals in managing such event.

Mohmad Saleem Jahangir (2009) attempted to highlight the influence of the alien culture both within and outside the families on the aged of Pandit Community. They live practically in every corner of the world — from the migrant camps in the outskirts of Jammu city, to medium towns and metropolises in India, Europe, North America and Africa. This minority community is agonizing in its eighteenth of displacement, which has resulted in loss of their land, property, homes, educational and employment opportunities, besides leading to breakup of families, social and cultural communities. The aged ones who migrated along with their younger ones witnessed a different situation in terms of their adjustment in the alien cultures

and subsequently the growth and development of their new generation in the shelter of those cultures created an unfamiliar culture within families also.

Wilson et al (2010) tested the hypothesis that higher level of childhood adversity is associated with lower level of psychosocial adjustment in old age. Participants were 253 older persons (mean age: 79.8, standard deviation: 2.1; 73.9% women) from the Rush Memory and Aging Project, a clinicopathologic study of common chronic conditions of old age. Childhood adversity was assessed with a 16-item measure based on portions of the Childhood Trauma Questionnaire and other inventories. Psychosocial adjustment was assessed with multiple measures of tendencies to experience negative emotional states and to be socially engaged. Based in part on a factor analysis, composite measures of total adversity, emotional neglect, parental intimidation, parental violence, family turmoil, and financial need were developed. In a series of linear regression models adjusted for age, sex, own education, and parental education, the composite measure of childhood adversity was associated with all facets of neuroticism and accounted for more than 13% of the variance in the composite neuroticism measure. Emotional neglect and parental intimidation had the strongest associations with neuroticism. Childhood adversity was not related to frequency of participation in social activities, but more adversity was associated with having a smaller network (accounting for 3% of the variance) and feeling more emotionally isolated (accounting for 7% of the variance). It was found that childhood adversity is associated with less adaptive psychosocial functioning in old age. The results suggest that traumatic experiences in childhood may adversely affect critical components of psychosocial adjustment in old age.

A comparative study was conducted by Cherian (2003) in Ludhiana city on the level of satisfaction derived by the aged living with families and in senior citizens homes. Level of satisfaction with various needs like food, clothing, and housing were assessed. Hundred and twenty elderly were compared. Results revealed that majority of aged living with families were satisfied with various types of needs. On the other hand, majority of respondents living in senior citizen homes were not satisfied even with their basic needs of food, clothing and housing.

METHODOLOGY

Methodology is the description, explanation and justification of various methods of conducting research. Methodology is used to give a clear cut idea on what the researcher is carrying out in his or her research. In order to plan at a right point of time and to advance the research work, methodology makes the right platform to the researcher to mapping out the research work in relevance to make solid plans (Jennifer Williams, 2011).

The methodology of the present study involved the following:

- Objectives
- Research Questions
- Hypotheses
- Area
- Sample
- Tools

- Procedure
- Analysis of Data

OBJECTIVES:

The objectives of the present study are as follows:

1. To find the level of depression in selected old people.
2. To find the level of anxiety in selected old people.
3. To find the level of adjustment in selected old people.
4. To find out the difference in the levels of depression, anxiety and adjustment with respect to gender.
5. To find out the relationship between depression, anxiety and adjustment among the selected sample.

RESEARCH QUESTIONS:

1. What is the level of depression in the selected old people?
2. What is the level of anxiety in the selected old people?
3. What is the level of adjustment of the selected old people?
4. Do the levels of depression, anxiety and adjustment of the sample differ with respect to gender?
5. Does any relationship exist between depression, anxiety and adjustment in the selected sample?

HYPOTHESES:

1. The level of depression in the selected old people will be Severe.
2. The level of anxiety of the sample will be Severe.
3. The level of adjustment of the sample will be Poor.
4. There will be no statistically significant difference in depression, anxiety and adjustment between the selected old age men and women.
5. There will be no significant relationship between depression, anxiety and adjustment among the selected old people.

SAMPLE:

From various old age homes in Coimbatore, 104 old persons (40 male and 64 female) in the age range of 60-90 years were selected by Purposive Sampling. Purposive sampling is a sampling technique in which the individual units are selected by some purposive method. Most of them (50%) are from low socio economic background, 45% are from middle socio economic background and 5% are from upper middle class of society.

AREA OF THE SAMPLE:

Old age homes in and around Coimbatore City was the area of the study. The reasons for selecting this area are given below:

- Residing place of the investigators.
- Availability of the required number of sample.
- Co-operative rendered by the sample to the researcher.

- Convenience of administering the test to the sample.



TOOLS:

Personal Data Sheet was used to collect the relevant background of the selected old people, like age, gender, marital status, ways adopted by them to manage tension, causes of anxiety/depression, etc. Geriatric Depression Scale was used to assess the level of Depression of the sample. This scale consists of 30 questions which have to be responded by giving Yes or No. Each Yes response carries a score of 1. The total scores are summed and interpreted using the norms. The level of anxiety of the sample was measured by Hamilton Anxiety Scale (Hamilton, 1959). It consists of 14 items related to the symptoms of anxiety experienced by the sample over the past one week. Scores are interpreted with the help of the norms. The adjustment of the sample was assessed by the Holmes-Rahe Social Readjustment Rating Scale. It consists of 43 items related to the situations/events experienced by the sample for the past 12 months.

PROCEDURE:

Initially, permission was obtained from the authorities of different old age homes in Coimbatore. Then, the investigators established rapport with the inmates of the old homes. They gave the personal data sheet to each of them and collected relevant personal background details. Later, Geriatric Depression Scale, Hamilton Anxiety Scale and Social Readjustment Rating Scale were provided to the inmates individually, one after the other. They were asked to respond to the questionnaires as per the given instructions. Their scores were recorded and as per the norms, they were interpreted. Out of the total sample, 97 [33 males, 64 females] old people whose responses to all the questionnaires were complete, were selected as the sample. The results are tabulated and taken for further discussion.



EXPERIMENTAL DESIGN:

A single group pre-test design was used in this study.

ANALYSIS OF DATA:

The tabulated results were statistically analyzed using percentage analysis, correlation, chi-square and t-test.

RESULTS AND DISCUSSION

TABLE I
LEVEL OF DEPRESSION OF THE SAMPLE

N = 97

LEVEL OF DEPRESSION	NUMBER	PERCENTAGE
NORMAL	20	21
MILD	59	61
SEVERE	18	18

Percentages are rounded off

It is displeasing to note that 18% of the sample has Severe Depression. They seem to be highly traumatic, in low mood and greatly disturbed. They often feel confused and forgetful. It is observed from the table that most of the samples (61%) have Mild Depression. They seem to be apparently sad and have pessimistic thoughts. They also seem to have inner tension, reduced sleep, reduced appetite, suicidal thoughts and concentration difficulties and lassitude. Hence, the null hypothesis, “The level of depression of the selected old people will be High” is accepted.

Similar results were found in the study by Gabryelewicz, Styczynska, Pfeffer, Wasiak, Barczak, Luczywek, Androsiuk & Barcikowska (2004) detected the prevalence of depressive syndromes and symptoms in the sample of elderly persons with Mild Cognitive Impairment. The subjects of the study were 102 consecutive out-patients with MCI. Three patient groups emerged according to the depressive symptoms distribution and severity scores basis: those with major depression constituted 19.6% (n = 20), with minor depression 26.5% (n = 27), and with very few depressive symptoms 53.9% (n = 55). It was concluded that both major and minor depression is common in MCI.

FIGURE I
LEVEL OF DEPRESSION OF THE SAMPLE

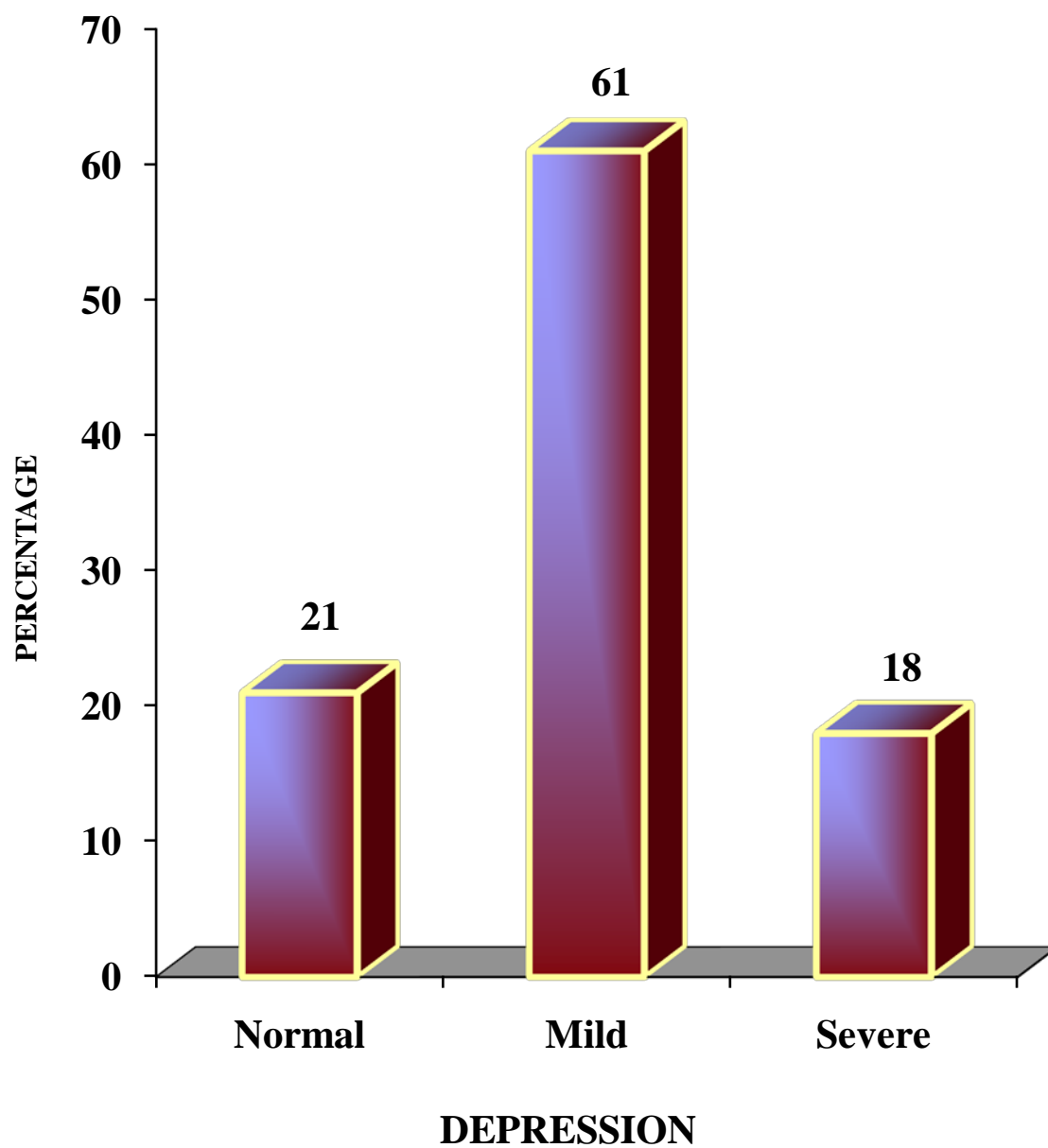


TABLE II
LEVEL OF DEPRESSION IN MALE AND FEMALE SAMPLE

LEVEL OF DEPRESSION	MALE (N=33)		FEMALE (N=64)	
	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
NORMAL	5	15	16	25
MILD	19	58	40	63
SEVERE	9	27	8	12

Percentages are rounded off

It is observed from the table that more percentage of male sample have Severe Depression (27%) compared to the female sample (12%). However, Mild Depression is found to be more in the female sample (63%) than the male counterparts (58%). Also, Normal levels of Depression are observed more in the female sample (25%) than the males (15%). The rate of depression is more common among older women than older men. There are certain risk factors which are common in later life of women; some women may have to experience some panic situation or severe disease, which often can increase the chances of depression among them. Most often the elderly women could not handle the situation and become psychologically sick that can make them depressed.

In a study conducted by Forsell and Winblad (1999), similar results were found. They examined the prevalence of depression in a 3-year follow-up study of 875 non-depressed persons with a mean age of 85 years. It was found that 4.1% of the population was diagnosed as having a depression at the follow-up examination. The estimated first incidence was 1.4% per person year (0.8% in males and 1.5% in females).

FIGURE II
LEVEL OF DEPRESSION OF THE MALE AND FEMALE SAMPLE

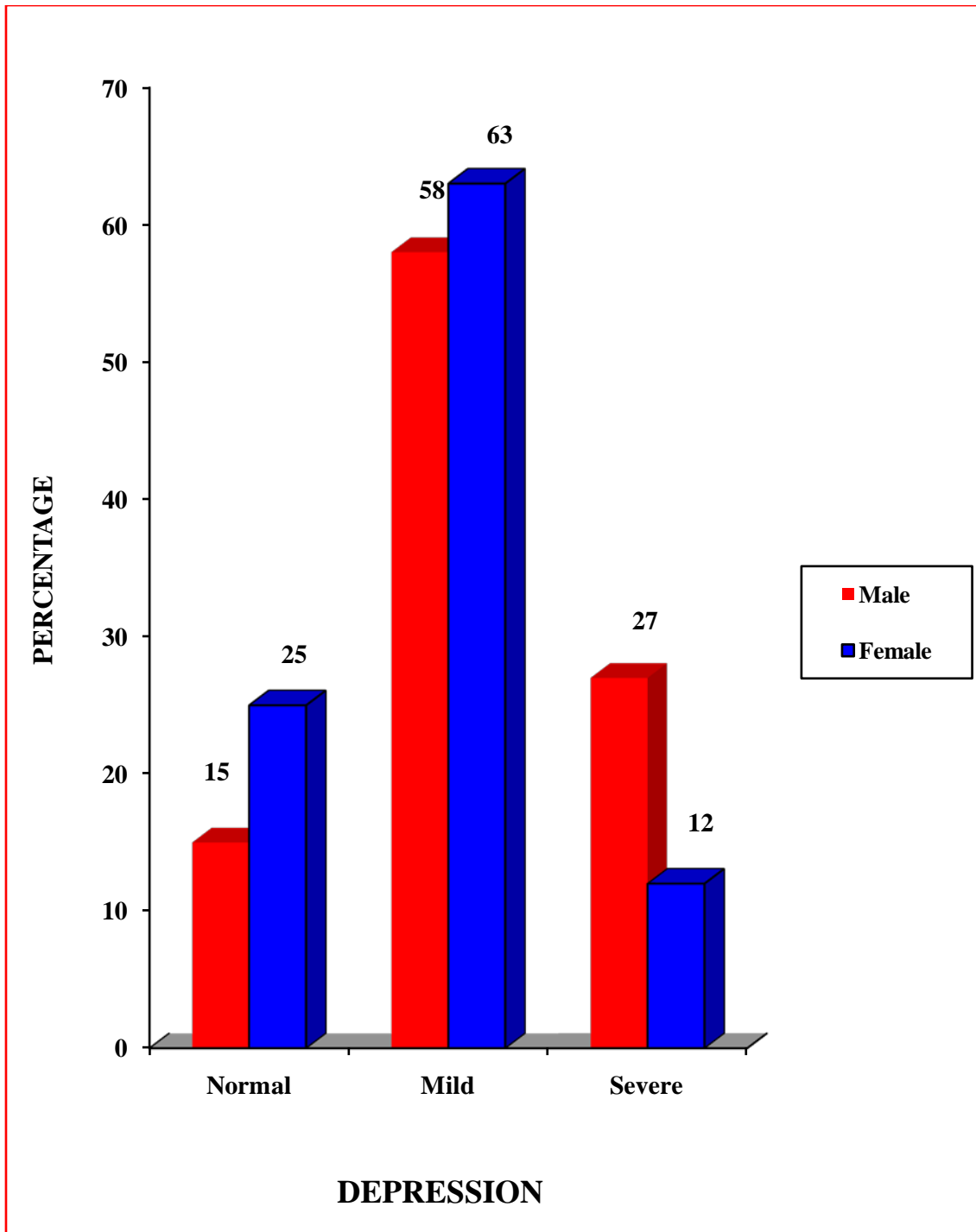


TABLE III
MEAN DIFFERENCE IN DEPRESSION OF THE MALE AND FEMALE SAMPLE

GENDER	MEAN DEPRESSION	STANDARD DEVIATION	t Value
MALE	15.33	4.88	0.15 NS
FEMALE	14.19	5.26	

NS = Not Significant

It is seen that the mean depression of the males is 15.33 and that of the females is 14.19. The mean values of both the male and female samples represent Mild Depression. The samples seem to have low mood and confusion. Though there is a slight difference in the mean values, it is not statistically significant (t value=0.15). Therefore, the hypothesis, “There will be no statistically significant difference in depression between the selected old age men and women” is accepted.

FIGURE III
MEAN DIFFERENCE IN DEPRESSION OF THE
MALE AND FEMALE SAMPLE

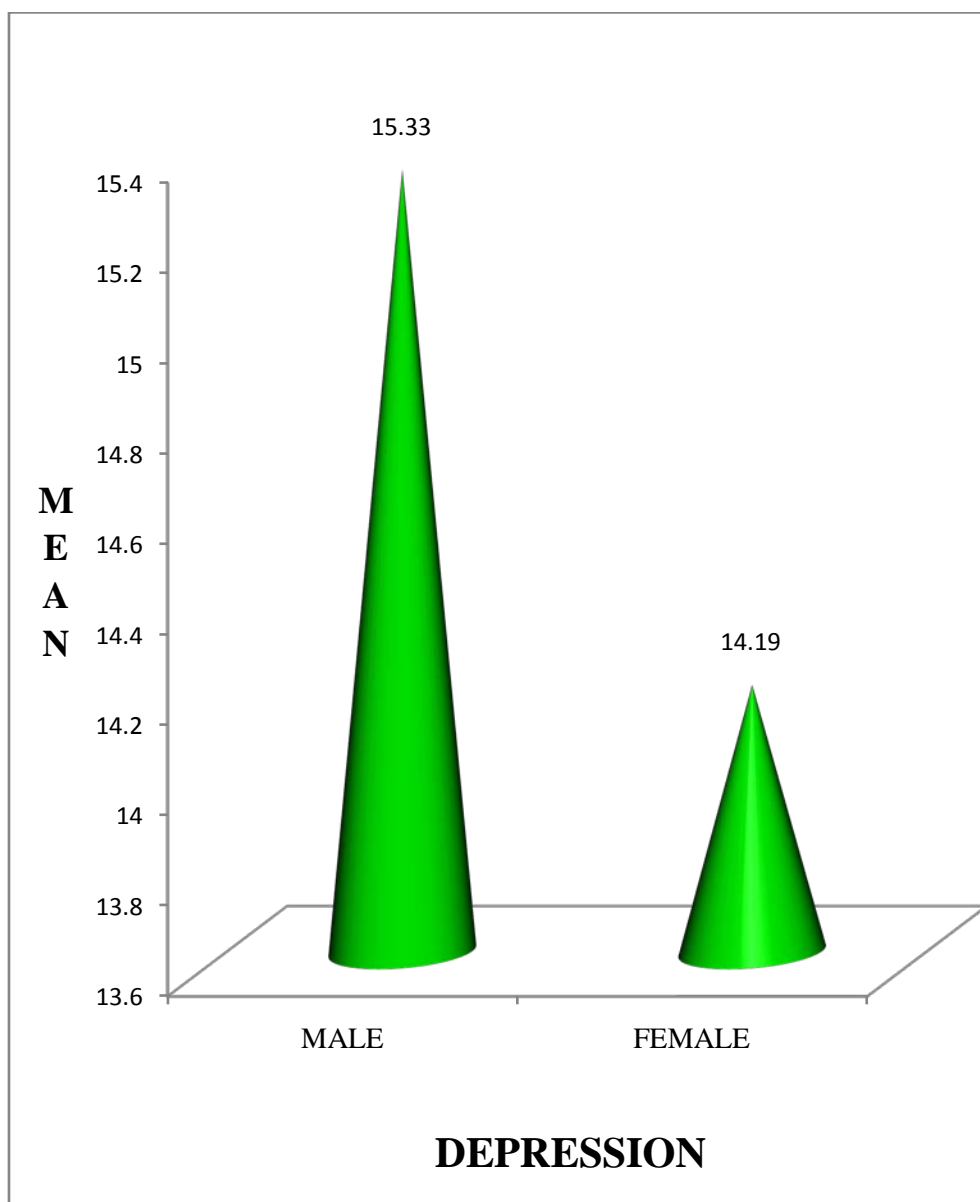


TABLE IV
LEVEL OF ANXIETY OF THE SAMPLE

N=97

LEVEL OF ANXIETY	NUMBER	PERCENTAGE
NORMAL	33	34
MILD	11	11
MODERATE	20	21
SEVERE	33	34

Percentages are rounded off

It is disheartening to see that 34% of the samples have Severe form of Anxiety. They seem to be in a constant state of worry and anxiousness. Though it is common for the elderly to worry more about things like deteriorating health and financial concerns as they age, the result of this study seems to be alarming as they appear to worry excessively about routine events. Thus, the hypothesis, “The level of anxiety of the sample will be Severe” is accepted.

Sheikh (1994) stated that the feeling of anxiety becomes problematic when the emotion causes disruptions to thoughts, behaviours and physical status. Abnormal amounts of anxiety correspond with illogical thoughts, irrational behaviours, and physical symptoms. Abnormal levels of anxiety cause a person to become distracted, irritable, or hostile; anxiety may cause tightness of the chest, dry mouth, sweating, and hyperventilation.

Moderate Anxiety is found in 21% of the sample and Mild Anxiety is reported by 11% of the sample. They seem to have difficulty relaxing, sleeping and concentrating and startle easily.

Regier et al. (1988) reported that 5.1% of the over 65 population experienced a diagnosable anxiety disorder, a rate which is lower than younger adult population. Further, it was found that anxiety disorders tend to be developmental--most older adults who are diagnosed with an anxiety disorder have maintained the condition throughout their lives.

FIGURE IV
LEVEL OF ANXIETY OF THE SAMPLE

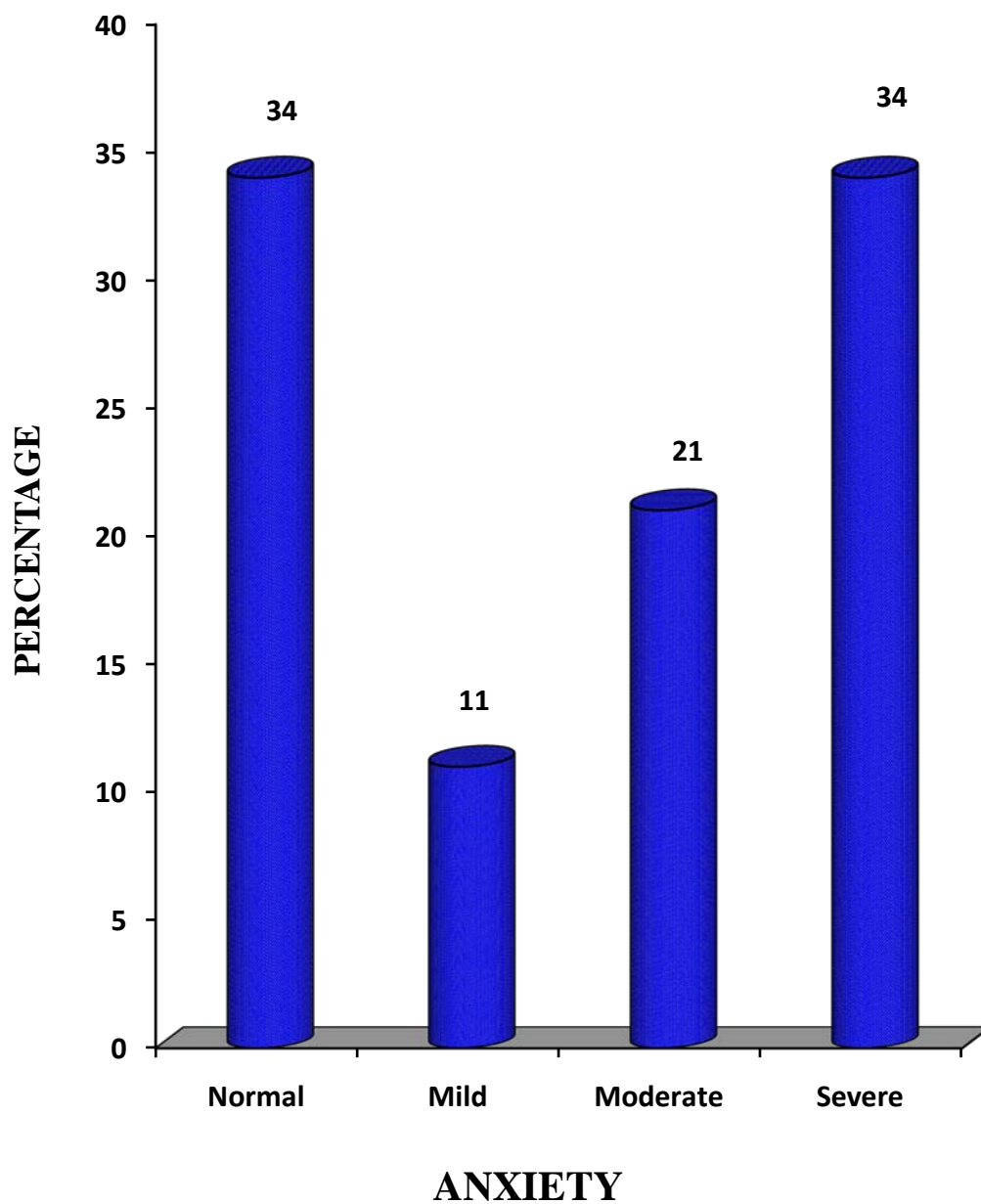


TABLE V
LEVEL OF ANXIETY IN MALE AND FEMALE SAMPLE

LEVEL OF ANXIETY	MALE (N=33)		FEMALE (N=64)	
	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
NORMAL	13	40	20	31
MILD	4	12	7	11
MODERATE	5	15	15	24
SEVERE	11	33	22	34

Percentages are rounded off

The above table clearly shows that Severe Anxiety is experienced by almost equal percentage of male and female samples (33% and 34% respectively). They have trouble in concentrating and seem to anticipate something worse to happen. Their apprehension seems to be very high and they seem to worry a lot over unwanted issues. This may affect their already deteriorating health due to old age. Moderate Anxiety is seen in 24% of the female and 15% of the male sample. These people are also seen to suffer from undue tension and worry. Along with physical ageing, their moderate anxiety seems to eat away their energy. They easily become tired. It is shown that 12% of the male and 11% of the female samples have Mild Anxiety. Though the anxiety is mild, it may not be good for them as they are already going through a declining phase in their lives.

In the study by Gary Koch, Andrew Sherwood, James Blumenthal, Jonathan, Davidson, Christopher O'Connor and Michael Sketch (2011), 934 heart disease patients, average age 62, completed a questionnaire measuring their level of anxiety and depression immediately before or after a cardiac catheterization procedure at Duke University Medical Center. Patients had anxiety if they scored 8 or higher on a scale composed of seven common characteristics of anxiety, with each item rated from 0 to 3 (range of possible scores: 0-21). It was found that 90 of the 934 patients experienced anxiety only, 65 experienced depression only and 99 suffered anxiety and depression.

FIGURE V
LEVEL OF ANXIETY IN MALE AND FEMALE SAMPLE

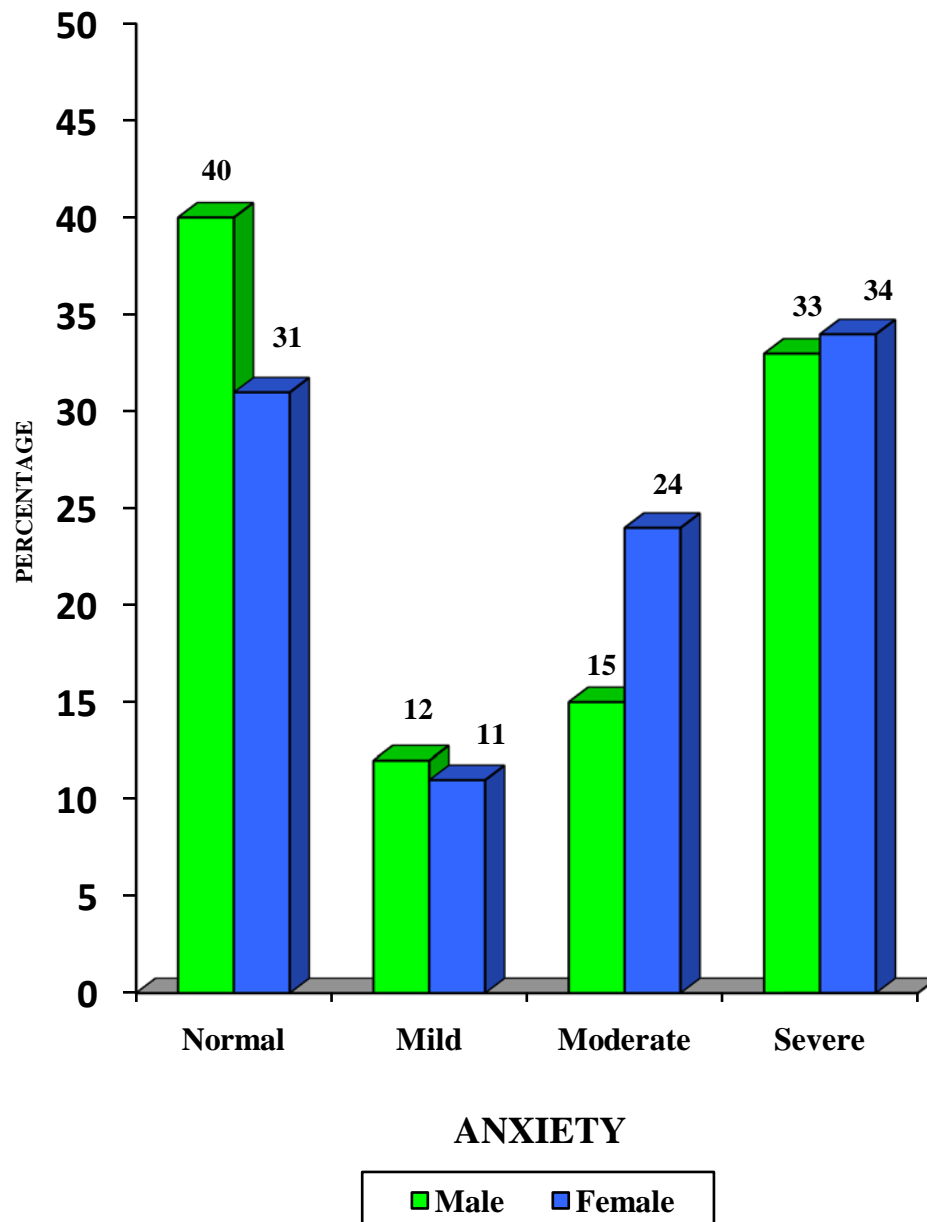


TABLE VI
MEAN DIFFERENCE IN ANXIETY OF THE
MALE AND FEMALE SAMPLE

GENDER	MEAN ANXIETY	STANDARD DEVIATION	t Value
MALE	17.94	8.85	0.187 NS
FEMALE	19.72	9.53	

NS = Not Significant

It is observed from the table that the male sample have a mean anxiety of 17.94 when compared to that of the female, who have 19.72 as mean anxiety. Their anxieties are in the Moderate level. Psychologists diagnose women with anxiety disorders two times as often as men, and research confirms that women are significantly more inclined toward negative emotion, self-criticism and endless rumination about problems.

The t-value calculated is 0.187, which is not significant. This shows that though there is slight difference in the mean anxieties of the male and female samples, it is not statistically significant. Hence, the hypothesis, “There will be no statistically significant difference in anxiety between the selected old age men and women” is accepted.

The result of the following study is similar to that of the above. *Iman Nazerian, Hasan Shahizan, Majid Foruzan and Alireza Zamani (2012) compared anxiety, cognitive and physical anxiety of male and female athletes competing at different levels. 263 elderly people over 65 years were surveyed. Questionnaires were used to collect data from a competitive state anxiety CSAI-2 ($\alpha = 0.838$) the data t, F test and Tukey HSD test were analyzed. Results indicated that male athletes than female athletes had less anxiety, cognitive and physical anxiety ($p < 0/01$). Athletes who compete at higher levels than the 2 company had experienced less cognitive anxiety ($p < 0/01$).*

FIGURE VI
MEAN ANXIETY OF THE MALE AND FEMALE SAMPLE

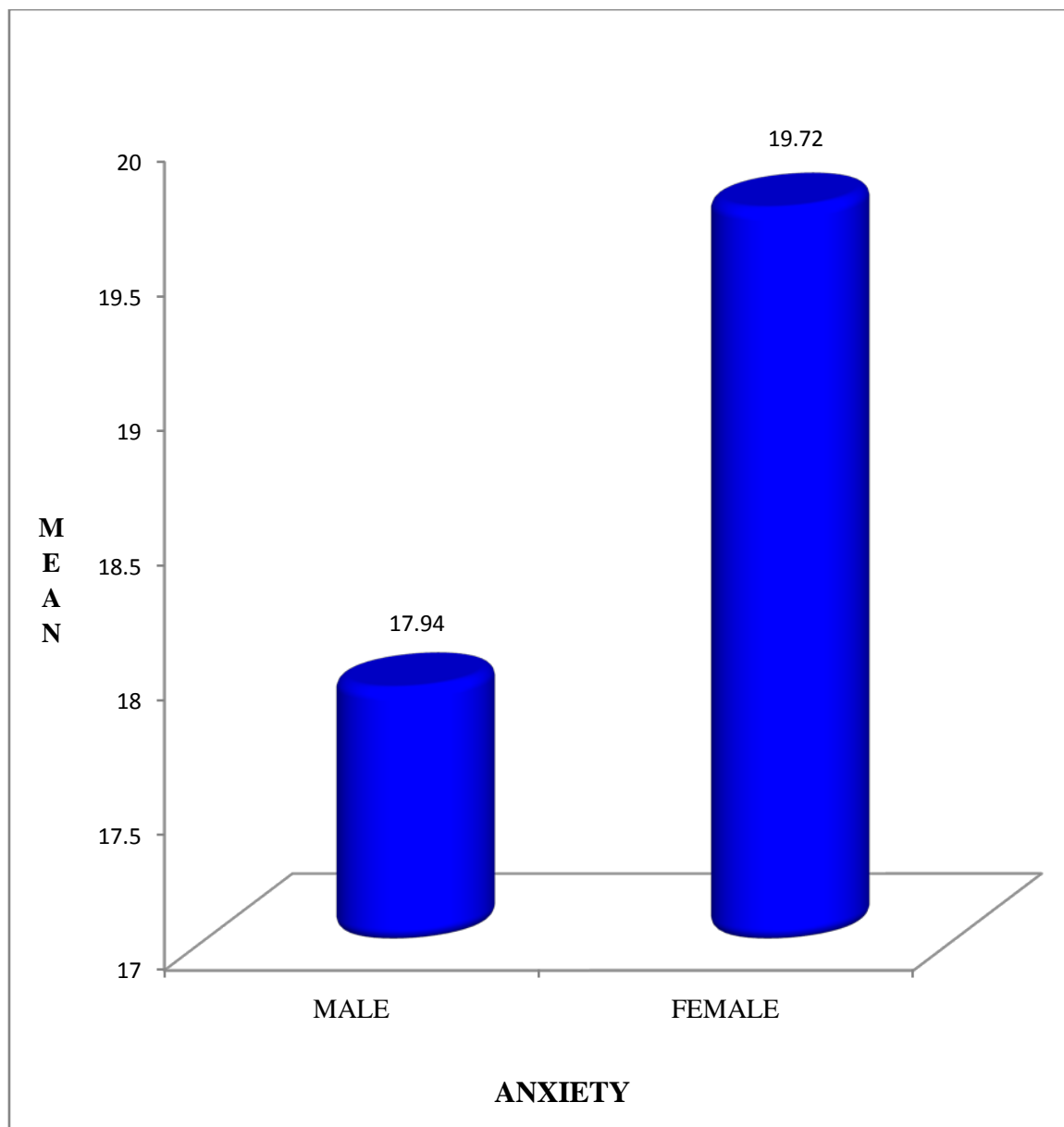


TABLE VII
LEVEL OF ADJUSTMENT OF THE SAMPLE

LEVEL OF ADJUSTMENT	NUMBER	PERCENTAGE
NORMAL	47	48
MILD	30	31
MODERATE	17	18
SEVERE	3	3

Percentages are rounded off

It is seen that Severe Adjustment problem is experienced by just three persons. They seem to be frustrated and unable to meet with the demands of life. As assumed, adjustments in old age seem to be difficult for the sample, because of the limited capacity of their age, their diminishing energy and declining mental abilities. Hence, the hypothesis, “The level of adjustment of the sample will be Poor” is accepted. Moderate Adjustment is seen in 18% of the sample. Mild problem of adjustment is seen in 31% of the sample. The people are not able to adapt themselves to the changes in physical and mental health as a result of old age.

Adjustment is “a process involving both mental and behavioural responses by which an individual strives to cope with inner needs, tensions, frustrations and conflicts and to bring harmony between these inner demands and those imposed upon him by the world in which he lives,” if the conflicts are solved to satisfy the individual needs within the tenets approved by the society the individual is considered adjusted. The degree of success depends upon the individual’s adaptability. The world will not adopt itself to the elderly, only the elderly will have to adopt themselves to the world.

FIGURE VII
LEVEL OF ADJUSTMENT OF THE SAMPLE

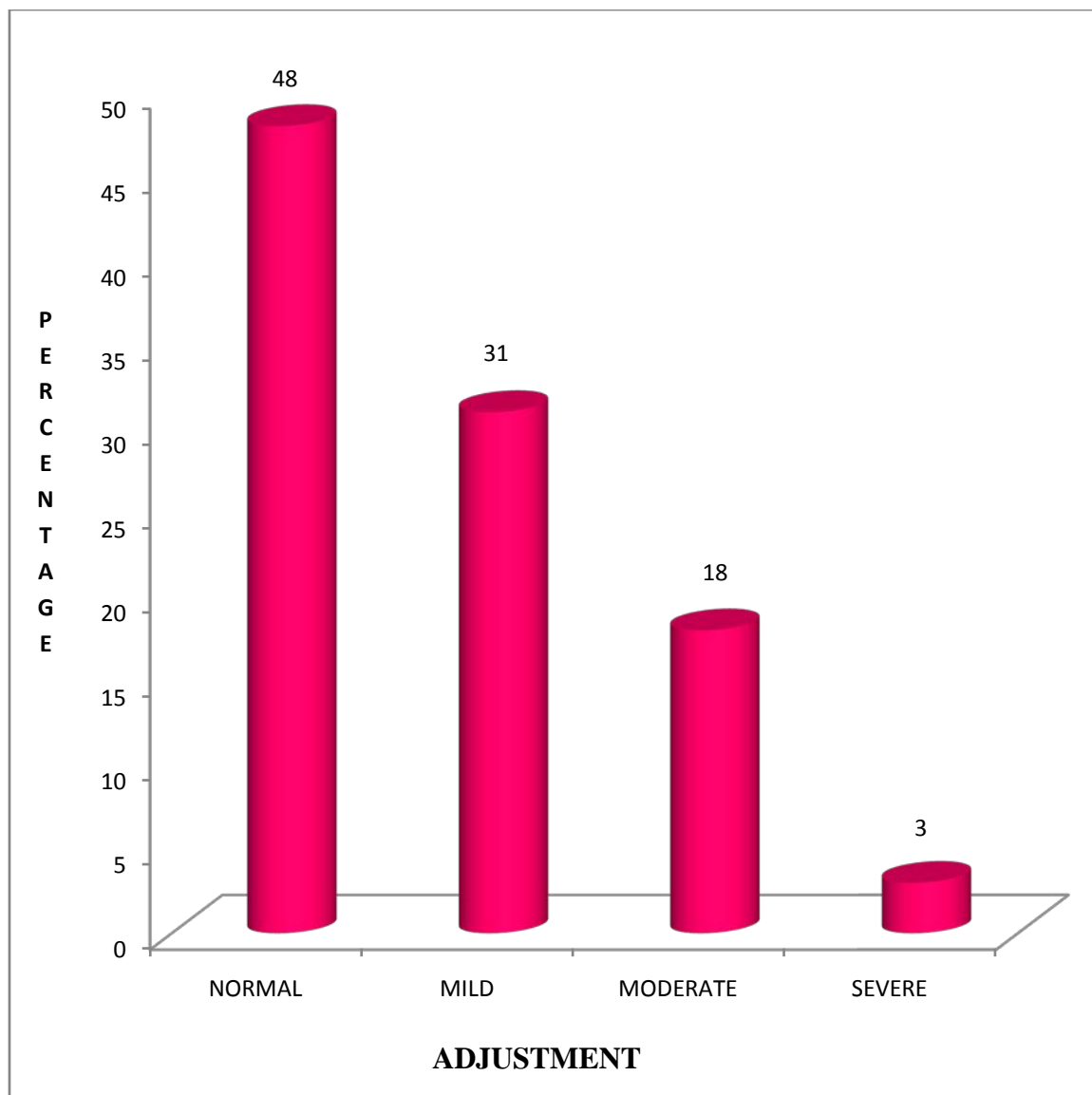


TABLE VIII
LEVEL OF ADJUSTMENT OF THE MALE AND FEMALE SAMPLE

LEVEL OF ADJUSTMENT	MALE (N==33)		FEMALE (N=64)	
	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
NORMAL	8	24	39	61
MILD	21	64	9	14
MODERATE	4	12	13	20
SEVERE	0	0	3	5

Percentages are rounded off

It is noted that Severe Adjustment problem is experienced by 3 female members of the group. Their capacity to adapt to the personal and environmental changes is very less. Their old age is not helping them to fulfil their aspirations as expected. It is also seen 20% of the female and 12% of the male samples have Moderate Adjustment problems. 64% of the male and 14% of the female samples experience Mild Adjustment problems. These people seem to be unable to cope with the issues and changes in their life. They also seem to have over expectations, but, due to old age, they are not able to meet with those. As a result of which they experience lot of adjustment related issues.

FIGURE VIII
LEVEL OF ADJUSTMENT OF THE MALE AND FEMALE SAMPLE

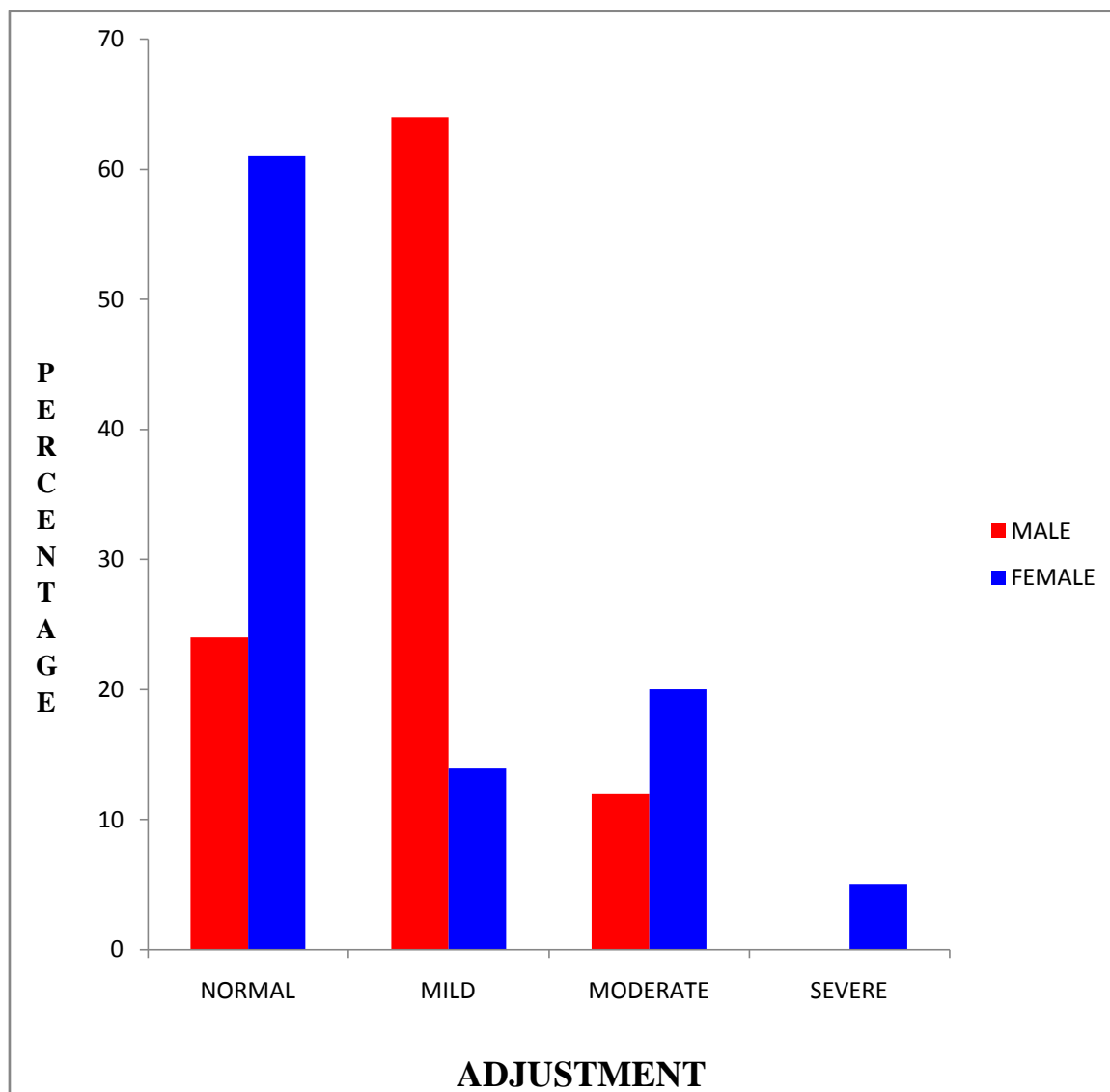


TABLE IX
MEAN DIFFERENCE IN ADJUSTMENT OF THE
MALE AND FEMALE SAMPLE

GENDER	MEAN ADJUSTMENT	STANDARD DEVIATION	t Value
MALE	16	6.03	0.43 NS
FEMALE	16.23	6.3	

NS = Not Significant

It is understood from the above table that the female samples have a Mean adjustment of 19.72 and the male sample have 17.94 as Mean adjustment. The calculated t value ($t=0.187$) is not statistically significant. Therefore, the hypothesis, “There will be no statistically significant difference in adjustment between the selected old age men and women” is accepted. The differences in the mean scores of adjustment for the male and female sample seem to be very less and hence, there is no significant difference. Both the genders suffer mild and moderate adjustment problems in varying degrees and they seem to be unable to cope with the changes of old age.

FIGURE IX
MEAN DIFFERENCE IN ADJUSTMENT OF THE
MALE AND FEMALE SAMPLE

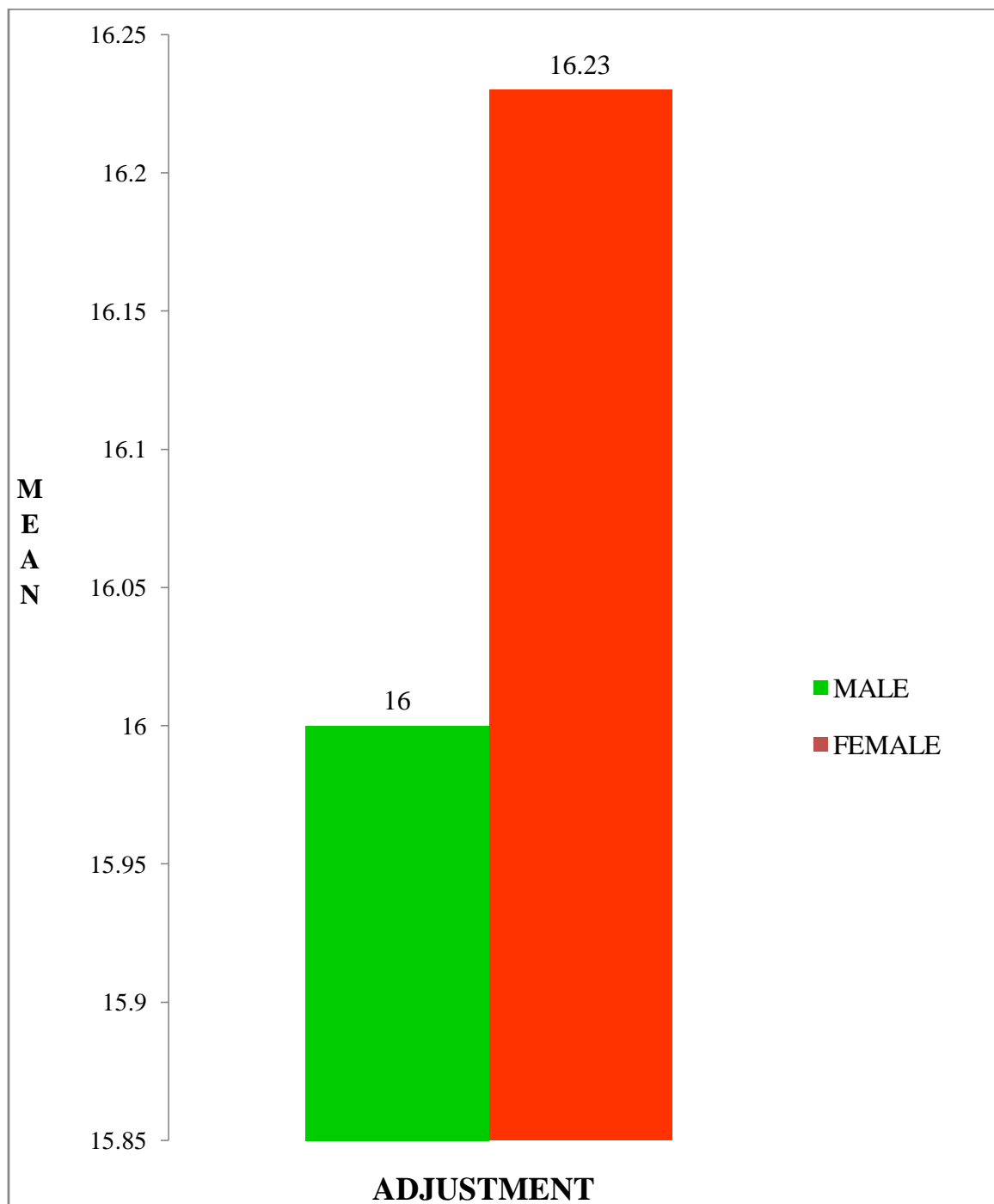


TABLE X
SIGNIFICANCE OF DEPRESSION, ANXIETY AND ADJUSTMENT
OF THE SAMPLE WITH RESPECT TO AGE

DEPRESSION	AGE		TOTAL
	60-65 YEARS	ABOVE 65 YEARS	
NORMAL	7 (5)	12.4 (15)	20
MILD	20.65 (22)	36.58 (37)	59
SEVERE	6.3 (8)	11.16 (10)	18
TOTAL	35	62	97
ANXIETY	60-65 YEARS	ABOVE 65 YEARS	TOTAL
NORMAL	11.55 (13)	20.46 (20)	33
MILD	3.85 (2)	6.82 (9)	11
MODERATE	7 (7)	12.4 (13)	20
SEVERE	11.55 (13)	20.46 (20)	33
TOTAL	35	62	97
ADJUSTMENT	60-65 YEARS	ABOVE 65 YEARS	TOTAL
NORMAL	23.5 (31)	22.09 (16)	47
MILD	15 (11)	14.1 (19)	30
MODERATE	8.5 (7)	7.99 (10)	17
SEVERE	1.5 (1)	1.41 (2)	3
TOTAL	50	47	97

The calculated chi-square value for Depression and Age is 0.88, which is lower than the table value, is not statistically significant. Therefore, it is clearly understood that age has not influenced the level of depression of the sample. Likewise, the chi-square value for Age and Anxiety is 0.66 is lesser than the table value and so, it is not statistically significant. Here again, age has no significant influence over the experience of anxiety of the sample. The chi-square value for Age and Adjustment is 2.66, which is lower than the table value, is not significant. This shows that for adjustment also age has no significant influence.

TABLE XI
CORRELATION BETWEEN DEPRESSION, ANXIETY AND ADJUSTMENT OF
THE SAMPLE

VARIABLES	MEAN	STANDARD DEVIATION	r VALUE
DEPRESSION	14.58	5.133	0.061 NS
ANXIETY	19.11	9.29	
DEPRESSION	14.58	5.133	-0.13 NS
ADJUSTMENT	16.15	6.18	
ANXIETY	19.11	9.29	0.26 NS
ADJUSTMENT	16.15	6.18	

It is noted from the above table that there is a positive correlation between Depression and Anxiety ($r=0.061$) and Anxiety and Adjustment ($r=0.26$). But, this relationship is not statistically significant. This reveals that the level of anxiety increases when the level of depression is more.

There is a negative relationship between Depression and Adjustment ($r=-0.13$). This also is not statistically significant. When the level of depression increased, it has affected the adjustment of the sample.

Therefore, the hypothesis, “There will be no significant relationship between depression, anxiety and adjustment among the selected old people” is accepted.

SUMMARY AND CONCLUSION

Population ageing is a worldwide phenomenon. In India, the trend has resulted in various challenges on account of gradual erosion of the traditional joint family system and the inability of government to support any section of the elderly population besides retired government employees (Siva Raju, 2000). An old age home is usually the place, a home for those old people who have no one to look after them or those who have been thrown out of their homes by their children. A single visit to an old age home brings depression to the onlooker as, no one - Yes, no one seems to be happy there.

Depression is the most common psychiatric illness of late life. The most common emotional disorder in the elderly population is depression, which is often overlooked by health care professionals and family members (Jones, 2003). Anxiety may affect twice as many older adults as depression, according to new research. Seniors may experience more troublesome anxiety than other age groups for several reasons: they experience more losses, suffer from more pain and chronic conditions, are often on multiple medications that might exacerbate anxiety. 'Adjustment' and 'life satisfaction' are important components of successful ageing. 'Adjustment' is defined as 'the restructuring of the individual's attitude and behaviour in response to the new situation by integrating his/her expression with the expectations and demands of society'.

In fact, the elderly in India face a multitude of psychological, social and physical health problems. As age advances, there is increased morbidity and functional loss. Such emotional effect should be handled in a better way and with immediate preventive measures. The goal of this study is to explore the magnitude and risk factors of the problem of depression in elderly people residing in the old age homes.

The objectives of the present study are as follows:

1. To find the level of depression in selected old people.
2. To find the level of anxiety in selected old people.
3. To find the level of adjustment in selected old people.
4. To find out the difference in the levels of depression, anxiety and adjustment with respect to gender.
5. To find out the relationship between depression, anxiety and adjustment among the selected sample.

From various old age homes in Coimbatore, 104 old persons in the age range of 60-90 years were selected by Purposive Sampling. Most of them (50%) are from low socio economic background, 45% are from middle socio economic background and 5% are from upper middle class of society.

Personal Data Sheet was used to collect the relevant background of the selected old people. Geriatric Depression Scale was used to assess the level of Depression of the sample. The level of anxiety of the sample was measured by Hamilton Anxiety Scale (Hamilton, 1959). The adjustment of the sample was assessed by the Holmes-Rahe Social Readjustment Rating

Scale. Out of the total sample, 97 [33 males, 64 females] old people whose responses to all the questionnaires were complete, were selected as the sample.

The results are tabulated and taken for further discussion.

CONCLUSION:

1. 18% of the samples have Severe Depression. Most of the samples (61%) have Mild Depression.
2. More percentage of male sample have Severe Depression (27%) compared to the female sample (12%). However, Mild Depression is found to be more in the female sample (63%) than the male counterparts (58%). Also, Normal levels of Depression are observed more in the female sample (25%) than the males (15%).
3. The mean depression of the male sample is $M=15.33$ and that of the females is $M=14.19$. This difference is not statistically significant ($t=0.15$).
4. 34% of the samples have Severe form of Anxiety. Moderate Anxiety is found in 21% of the sample and Mild Anxiety is reported by 11% of the sample.
5. Severe anxiety is experienced by 33% of the male and 34% of the female sample. Moderate anxiety is observed in 15% of the male and 24% of the female samples.
6. The mean anxiety of the male sample is 17.94 and that of the females is 19.72. The mean difference is not statistically significant ($t=0.187$).
7. Adjustment problems is Severe in 3%, Moderate in 18% and Mild in 31% of the of the sample.
8. Severe Adjustment problems are faced by 3 female members of the group, while 20% of them have Moderate Adjustment and 14% have Mild Adjustment problems. In men, 12% have Moderate and 64% have Mild Adjustment problems.
9. Mean adjustment of the males is 16 and the mean adjustment of the females is 16.23. The mean difference is not statistically significant ($t=0.43$).
10. Chi-square calculated to find the influence of age on Depression, Anxiety and Adjustment shows that Age as got no significant influence on these variables.
11. There is a slight positive correlation between Depression and Anxiety ($r=0.06$), which is not significant. The correlation between Anxiety and Adjustment is 0.26 and the correlation between Depression and Adjustment is -0.13. The correlations values are not significant for any of these variables.

LIMITATIONS OF THE PRESENT STUDY

1. The results of this study cannot be generalized as the samples have been selected only from selected places in Coimbatore. Large and varied sample could have been included.
2. The samples have selected from old age homes. Those living with their families have been left out. Hence, these results could not be compared and generalized.
3. Only descriptive study was carried out. Intervention programme could have been given to the sample.
4. Some more psychological variables could have been included, as it is only a descriptive study.

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ANNEXURES**GERIATRIC DEPRESSION SCALE**

Name:

Date:

There are a few questions given below that indicates your general mood and interests. Please read each question carefully, think about them in context of your situations over the last one year and say YES or NO.

1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you hopeful about the future?
6. Are you bothered by thoughts you can't get out of your head?
7. Are you in good spirits most of the time?
8. Are you afraid that something bad is going to happen to you?
9. Do you feel happy most of the time?
10. Do you often feel helpless?
11. Do you often get restless and fidgety?
12. Do you prefer to stay at home, rather than going out and doing new things?
13. Do you frequently worry about the future?
14. Do you feel you have more problems with memory than most?
15. Do you think it is wonderful to be alive now?
16. Do you often feel downhearted and blue?
17. Do you feel pretty worthless the way you are now?
18. Do you worry a lot about the past?
19. Do you find life very exciting?
20. Is it hard for you to get started on new projects?
21. Do you feel full of energy?
22. Do you feel that your situation is hopeless?
23. Do you think that most people are better off than you are?
24. Do you frequently get upset over little things?
25. Do you frequently feel like crying?
26. Do you have trouble concentrating?
27. Do you enjoy getting up in the morning?
28. Do you prefer to avoid social gatherings?
29. Is it easy for you to make decisions?
30. Is your mind as clear as it used to be?

HOLMES-RAHE SOCIAL READJUSTMENT RATING SCALE

IDENTIFIER

DATE

This questionnaire asks about the number of events you have endured over the last 12 months and shows how they can add up in terms of their effects. Each of the listed events has a score - the higher the score, the higher the stress associated with the event. Identify which have happened to you in the last 12 months by ticking them.

1. Death of a spouse		25. Outstanding personal achievement
2. Divorce		26. Spouse starts or stops work
3. Marital separation		27. Begin or end school
4. Imprisonment		28. Change in living conditions
5. Death of a close family member		29. Revision of personal habits
6. Personal injury or illness		30. Trouble with boss
7. Marriage		31. Change in working hours or conditions
8. Dismissal from work		32. Change in residence
9. Marital reconciliation		33. Change in schools
10. Retirement		34. Change in recreation
11. Change in health of family member		35. Change in church activities
12. Pregnancy		36. Change in social activities
13. Sexual difficulties		37. More minor mortgage or loan
14. Gain a new family member		38. Change in sleeping habits
15. Business readjustment		39. Change in number of family reunions
16. Change in financial state		40. Change in eating habits
17. Death of a close friend		41. Holiday
18. Change to a different line of work		42. Christmas
19. Change in frequency of arguments		43. Minor violation of law
20. Major mortgage or loan		
21. Foreclosure of mortgage or loan		
22. Change in responsibilities at work		
23. Child leaving home		
24. Trouble with in-laws		

HAMILTON ANXIETY SCALE

Name:

Date:

Please read each statement and select a number 0, 1, 2, 3, or 4 which indicates the severity of symptoms over the past week.

0 = none 1 = mild 2 = moderate 3 = severe 4 = very severe

S.No.	Statements	Response
1	ANXIOUS MOOD – worries, anticipates the worst	
2	TENSION – startles, restless, cries easily, trembling	
3	FEARS – of the dark, strangers, being alone, animals, crowds	
4	INSOMNIA – difficulty falling asleep or staying asleep, nightmares	
5	INTELLECTUAL – poor concentration, memory, decision making ability	
6	DEPRESSED MOOD – decreased interest in activities, anhedonia, insomnia	
7	SOMATIC COMPLAINTS: MUSCULAR – muscle aches or pains, bruxism	
8	SOMATIC COMPLAINTS: SENSORY – tinnitus, blurred vision, tingling, numbness	
9	CARDIOVASCULAR – tachycardia, palpitations, chest pain, feeling faint	
10	RESPIRATORY SYMPTOMS – chest pressure, choking, shortness of breath	
11	GASTROINTESTINAL – dysphasia, nausea or vomiting, constipation, weight loss, abdominal fullness, sinking feeling in abdomen, dyspepsia	
12	GENITOURINARY – urinary frequency or urgency, dysmenorrhoea, impotence	
13	AUTONOMIC – dry mouth, flushing, pallor, sweating, dizziness	
14	BEHAVIOUR AT INTERVIEW – fidgets, tremor, paces	

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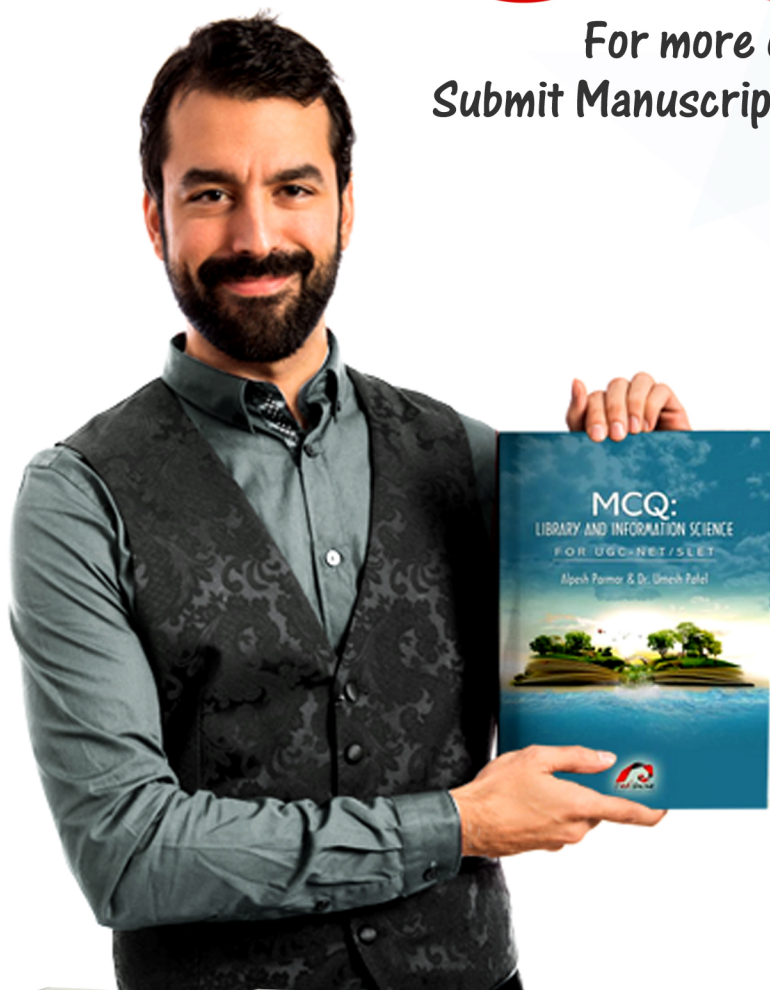
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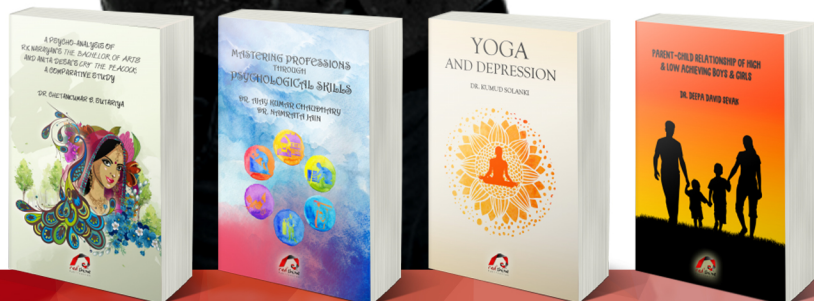
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